STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14972 — 14974

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: ANN	Last: ADAMS	2a. DATE OF DEATH: Month OCTOBER Day 2, Year 1972		2b. HOUR: 11:28 PM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: JUNE 29, 1901		6. AGE (In years last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RD 1			
14. FATHER'S NAME First: HARRY	Middle	Last: HITCHINS	15. MOTHER'S MAIDEN NAME First: MARY	Middle	Last: STEIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 212-74-9176	17. INFORMANT: MRS. LORRAINE RICHARDS,	Address: FROSTBURG, MD., RT. 1			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	4109 Acute myocardial ischemic disease	
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary insufficiency Arteriosclerosis Ht Disease	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus & marked instability & hyper & hypo glycemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from ____, 19__, to 2 Oct 72, 19__, that (I) (we) last saw the deceased alive on 2 Oct 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/3/72

22d. PHYSICIAN'S NAME (Type): S.G. WEISMAN, M.D. — 22e. ADDRESS: 59 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: OCT. 5, 1972	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24. FUNERAL DIRECTOR: DURST FUNERAL HOME,	ADDRESS: FROSTBURG, MD. 21532	25a. REC'D BY REGISTRAR DATE: OCT 10 1972	25b. REGISTRAR'S SIGNATURE: Archaylor Norton	

DHMH - 163/72 25M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14973 — 14975

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M
(VR A15 (4))

	First	Middle	Last		
1. DECEASED-NAME (Type or print)	HANNAH	CECELIA	ALBRIGHT	2a. DATE OF DEATH Month / Day / Year	OCTOBER 30, 1972
2b. HOUR	8:50AM				
3. SEX	Female				
4. RACE	White				
5. DATE OF BIRTH	March 17, 1895				
6. AGE (In years last birthday)	77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country)	Md.				
7b. CITIZEN OF WHAT COUNTRY?	Allegany USA				
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐					
9. COUNTY OF DEATH	Allegany Md.				
10. CITY OR TOWN OF DEATH	Cumberland				
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART HOSPITAL				
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife				
12b. KIND OF BUSINESS OR INDUSTRY	Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.				
13b. COUNTY	Allegany				
13c. CITY OR TOWN	La Vale				
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐				
13e. STREET AND NUMBER	529 B St.				
14. FATHER'S NAME	Stephen Briner				
15. MOTHER'S MAIDEN NAME	Anna Huber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	no				
16b. SOCIAL SECURITY NO.					
17. INFORMANT Address	Mr. Edward A. Albright, La Vale, Md. Son				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	cachexia	6 months
DUE TO, OR AS A CONSEQUENCE OF (b)	Cancer of left breast	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) — UNDERLYING ☐
21b. TIME OF INJURY — HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-22-, 1972, to 10-30, 1972, that (I) (we) last saw the deceased alive on 10-30 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	L. Brings MD	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	10-31-72				
22d. PHYSICIAN'S NAME (Type)	LEWIS BRINGS, M.D.				
22e. ADDRESS	57 GREENE ST., CUMBERLAND, MD 21502				

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Nov. 2, 1972	Restlawn Gardens	La Vale, Md. Allegany	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
SCARPELLI FUNERALM HOME,	108 VIRGINIA AVE., CUMBERLAND, MD.	NOV 6 1972	Sidney H Norton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14974 — 14976

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: Ruth	Middle	Last: Andrews	2a. DATE OF DEATH Month: 10 Day: 20 Year: 72	2b. HOUR: M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: August 31, 1910	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Frostburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Community Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Florida Way		
14. FATHER'S NAME First: Charles	Middle	Last: Weber	15. MOTHER'S MAIDEN NAME First: Sarah	Middle	Last: Rennie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mr. Edgar Andrews "Husband"	Address: Lonaconing, Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial ischemia — 3 hr.
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary insufficiency — 1 yr.
DUE TO, OR AS A CONSEQUENCE OF
(c): Arteriosclerosis — 2 yrs.

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cardiac Arythmia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

Oct to 20

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 60 to ~~Aug~~, 19 72, that (I) (we) last saw the deceased alive on Oct 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Donley J MD		[X]	[ ]	[ ]	10.21.72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L R MILES JR MD	Lonaconing Md 21539

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	10/23/72	Memorial Park	Frostburg	A.	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	OCT 24 1972	Sidney H Norton

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14975

14977

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Harley	Middle: Vennerd ~~Xxxxxx~~	Last: Barnes	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ]	Month: 10	Day: 16	Year: 1972	2b. HOUR: 4:43p M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 6-21-83	6. AGE (In years last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month October Day 16 Year 1972		2d. HOUR: 4:43p M
7a. BIRTHPLACE (State or foreign country): W, Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.					
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital--DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Farm					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Springfield	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Star Route				
14. FATHER'S NAME First: Frank	Middle: P.	Last: Barnes	15. MOTHER'S MAIDEN NAME First: Alverta	Middle:	Last: Hardy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-10-6323	17. INFORMANT ADDRESS: Ralph R. Barnes, Fort Ashby, W, Va.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX] Inquiry [XX] and in my opinion death resulted from: Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: October 16, 1972

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/19/72	Fort Ashby Cemetery	Fort Ashby Mineral W, Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Keith S. Shaffer, Romney, W, Va.	OCT 20 1972	Sidney H. Norton

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14976

14978

Item#5,6,FilmG453 10/25/72 kam

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M (VR A15 (4))

1. DECEASED-NAME (Type or print): First ELTON; Middle VANTLER; Last BATES

2a. DATE OF DEATH: Month 10 Day 07 Year 72

2b. HOUR: 3:15 PM

3. SEX: Female

4. RACE: Colored

5. DATE OF BIRTH: 5/22/1919

6. AGE (In years last birthday): 53 YRS.

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

7a. BIRTHPLACE (State or foreign country): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Domestic Help

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumb Md.

13d. INSIDE CITY LIMITS? YES ☑ NO ☐

13e. STREET AND NUMBER: 303 Paca Street

14. FATHER'S NAME First Carl; Middle; Last Frisby

15. MOTHER'S MAIDEN NAME First Edna; Middle; Last Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 217-28-9828

17. INFORMANT: Address: Mr. John Bates Cumberland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Renal Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos ±

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Diabetic Nephropathy — 11 yr ±

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus — 17 yrs

2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease – Congestive Heart Failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10-2, 19 72, to 10-7, 19 72, that (I) (we) last saw the deceased alive on 10-7 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Werner Beck M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 10-9-72

22d. PHYSICIAN'S NAME (Type): WERNER BECK, M.D. Werner Beck M.D.

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/11/72

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo Pk.

23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md

24. FUNERAL DIRECTOR: Pearsall – STEIN'S FUNERAL HOME, CUMBERLAND, MD.

ADDRESS: 230 Baltimore Ave ~~FREDERICK STREET~~

25a. REC'D BY REGISTRAR DATE: OCT 13 1972

25b. REGISTRAR'S SIGNATURE: Sidney H. Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14977 — 14979

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Grace	Middle: D	Last: Bell	2a. DATE OF DEATH Month: 10 Day: 7 Year: 72	2b. HOUR: 1:35 A.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 1-11-96	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Hancock, Md.	7b. CITIZEN OF WHAT COUNTRY?: American	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Lions Manor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 62 Douglas Ave.		
14. FATHER'S NAME First: JOHN	Middle:	Last: MIKESELL	15. MOTHER'S MAIDEN NAME First: Alice	Middle:	Last: Pyle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-22-3748	17. INFORMANT: William Bell (SON)	Address: Lonaconing, Md.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes.

DUE TO, OR AS A CONSEQUENCE OF

(b): C.V.A with Right Hemiparesis. — 3mo.

DUE TO, OR AS A CONSEQUENCE OF

(c): Chr. A.S. Hypertensive Cardio vascular disease — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypothyroidism. Diabetes Mellitus. Chr. urinary tract infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from Aug 7, 19 72, to Oct 7, 19 72, that (I) (we) last saw the deceased alive on Oct 7 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A Topper M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-7-72		
22d. PHYSICIAN'S NAME (Type): John A Topper M.D.	22e. ADDRESS: Hyndman Pa		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/9/1972	23c. NAME OF CEMETERY OR CREMATORY: Sunsey Memorial Park	23d. LOCATION (City or Town): Cumberland, Md.	(County) / (State)
24. FUNERAL DIRECTOR: George Eichhorn	ADDRESS: Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE: OCT 11 1972	25b. REGISTRAR'S SIGNATURE: Sidney H Norton	

DHMH - 163/72 25M
(VR A15 (4))

14978

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14980

1. DECEASED-NAME (Type or print): First JON; Middle A.; Last BITTNER
2a. DATE OF DEATH: Month 10; Day 10; Year 72
2b. HOUR: 11:55PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: June 18, 1937
6. AGE (In years last birthday): 35 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Clerk
12b. KIND OF BUSINESS OR INDUSTRY: Drug Store
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 52 Oak St.
14. FATHER'S NAME: First Thomas; Middle R.; Last Bittner
15. MOTHER'S MAIDEN NAME: First Wilmeta; Middle; Last Cornwell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 001-28-1330
17. INFORMANT: Sister, Mrs. Mary Lou Bruggeman, Address Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF (b): Hepatic Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Edema
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) Weeks, (b) hrs, (c) years
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse lost.
5710

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify thot (I) (this hospitol) attended the deceased from 10 2 72, 19__, to 10 10 72, 19__ thot (I) (we) last saw the deceased alive on 10 10 72 19__, and that in (my) (our) opinion deoth occurred on the dote and hour ond from the couses stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE, DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10 13 72
22d. PHYSICIAN'S NAME (Type): Dr. W. Guy Fiscus, M.D.
22e. ADDRESS: Memorial Hospital Cumberland, Md. Medical Building

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 13, 1972
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 17 1972
25b. REGISTRAR'S SIGNATURE: Lindsay Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

OHMH-16 1/71 30M (VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14979

14981

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First / Middle / Last	Charles W. Bogan (Rev.)			2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Day Year	10-14-72 1972	2b. HOUR	4:35p M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	9-21-07	65 YRS.			October 14, 1972 19	4:35p M
7a. BIRTHPLACE (State or foreign country)	Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Allegany Md.
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Sacred Heart Hospital-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Priest, Catholic	12b. KIND OF BUSINESS OR INDUSTRY	Church
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Allegany	13c. CITY OR TOWN	Frostburg	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Route #2
14. FATHER'S NAME First / Middle / Last	Charles J. Bogan			15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary B. O'Neill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	Sister Miss Gertrude Bogan, Washington, D.C.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: OCTOBER 14, 1972

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 18, 1972	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME, CUMBERLAND, MARYLAND	OCT 19 1972	Sidney H. Norton

VR A15ME (S)
10M - 1/69

1975

1

14980

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14982

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CINDY	LOU	BOWSER	10 3 72	9:40A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
Female	White	10-20-61	10 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pa.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Student	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pa.	Somerset	Berlin	YES ☒ NO ☐	1132 E. Main

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David	R	Bowser	Peggy	Ellen	Poorbaugh

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	David R. Bowser 1132 E Main St. Berlin, P

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intra cranial hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b) Diabetic Keto acidosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2500

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 11 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ronald Moore	MD	☒	☐	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-6-72	I. O. O. F. Cemetery	Berlin, Somerset Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James R Lever	Johnson & Son Berlin, Pa.	OCT 10 1972	Sidney H Horton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14981 — 14983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Leslie	M.	Brinkman	Oct. 7 1972	1a 23 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	Aug. 2, 1904	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Retired Repairman	Body Shop

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	32½ Blackiston Ave.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
J. Howard Brinkman	Emma Gracie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-05-9328	Mrs.Eva Brinkman, Cumberland,Md. Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

1562

IMMEDIATE CAUSE (a) Far Advanced Carcinoma of the Ampulla of Vater — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF and Pancreas with Liver metastasis — 15 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospitol) attended the deceased from 9-19-57, 19____, to Oct., 1972, that (I) (we) last saw the deceased alive on 9-28-72 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
G. Overton Himmelwright MD	MD	☒	☐	☐	Oct.9,1972

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. G. Overton Himmelwright MD	133 Virginia Ave. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct.10,1972	Hillcrest Burial Park	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 17 1972	Sidney L. Norton

VR A15 (4) 45M - 7 69

1

14982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14984

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JONAS	Middle:	Last: BROADWATER	2a. DATE OF DEATH: Month 10 Day 22 Year 72	2b. HOUR: M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Oct. 10, 1871	6. AGE (In years last birthday): 101 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ~~Oct.~~ Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Self				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Garrett	13c. CITY OR TOWN: Swanton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rt. 2			
14. FATHER'S NAME First: William	Middle:	Last: Broadwater	15. MOTHER'S MAIDEN NAME First: Hester	Middle:	Last: Broadwater		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-48-3700	17. INFORMANT Address: Alvin Broadwater-Swanton, Md.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): DIABETES MELLITUS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 YEARS

2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ARTERIOSCLEROSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-19, 1972, to 10-22, 1972, that (I) (we) last saw the deceased alive on 10-22 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. L. Ballin M.D. DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-23-72	
22d. PHYSICIAN'S NAME (Type): R. BALLIN, M.D.	22e. ADDRESS: 51 GREENE ST., CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/25/72	23c. NAME OF CEMETERY OR CREMATORY: Broadwater	23d. LOCATION (City or Town) (County) (State): Rt. 2 Swanton-Garrett-Md	
24. FUNERAL DIRECTOR ADDRESS: BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT, MD. E. S. Boal	25a. REC'D BY REGISTRAR DATE: NOV 8 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton		

DHMH - 163/72 25M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14983 — 14985

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BENJAMIN		BUTLER	10	7	72	4:49 A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	8/3/72	0 YRS.	2	4		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Pa.	USA	NEVER MARRIED [X]	~~Allegheny~~ Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	infant	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pa.	Somerset	Meyersdale	YES [X] NO [ ]	622 Nith Street

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Claude	Eugene	Butler	Mary		Landis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline membrane disease
DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost. 7761

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (our) opinion death occurred an the date and haur and fram the causes stated above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert D Mitchell MD	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	10/8/72	Union Cemetery	Meyersdale, Som., Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Price Funeral Home	Meyersdale, Pa	OCT 16 1972	Lindsay H. Horton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14984 14986

1. DECEASED-NAME (Type or print): First NORA Middle C. CECELIA Last BYER
2a. DATE OF DEATH: Month 10 Day 25 Year 72
2b. HOUR: 8:20P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Jan. 21, 1889
6. AGE (In years last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland,
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife,
12b. KIND OF BUSINESS OR INDUSTRY: Own home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland,
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 36 Greene St.
14. FATHER'S NAME First Charles Middle -- Last Morgan
15. MOTHER'S MAIDEN NAME First Bridgett Middle -- Last Moran
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mr. J. Walter Byer, 36 Greene St. Md. 21502 Cumberland,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 d
DUE TO, OR AS A CONSEQUENCE OF (b): Mesenteric Thrombosis — 10 d
DUE TO, OR AS A CONSEQUENCE OF (c): Congestive Heart Failure — 57 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4270

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10/27/72
22d. PHYSICIAN'S NAME (Type): DR. BREZA & DR. MAZZACCO M. D.
22e. ADDRESS: SETON DRIVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/28/72
23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: GEORGE'S FUNERAL HOME GREENE ST. CUMBERLAND MD.
25a. REC'D BY REGISTRAR DATE: OCT 30 1972
25b. REGISTRAR'S SIGNATURE: Lidwyn Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14985 — 14987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4) 25m-1/70

1. DECEASED-NAME (Type or print): First: Sippie; Middle: M.; Last: Campbell
2a. DATE OF DEATH: Month: October; Day: 28; Year: 1972
2b. HOUR: @ 6:45 P.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 4/8/1885
6. AGE (In years last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): N.Carolina
7b. CITIZEN OF WHAT COUNTRY?: U.S. of America
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany County Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Allegany County Infirmary
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 212 Cecelia Street
14. FATHER'S NAME: First: Jay; Middle; Last: Mobley
15. MOTHER'S MAIDEN NAME: First: Nellie; Middle; Last: Campbell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
16b. SOCIAL SECURITY NO. (If yes give wor or dates of service): 238-36-6638A
17. INFORMANT: P.O.Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro - vascular accident
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4369
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 6/9, 1922, to 10/28, 1922, that (I) (we) last saw the deceased alive on 10/28 1922, and that in (my) (our) opinian death occurred an the date and hour and fram the causes stoted obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M. Simons DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒
22c. DATE SIGNED: 10/28/1972
22d. PHYSICIAN'S NAME (Type): George M. Simons, M.D.
22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 31, 1972
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Md.
24. FUNERAL DIRECTOR: Byron Kight
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: NOV 1 1972
25b. REGISTRAR'S SIGNATURE: Richard M. Norton

4 — 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14986 — 14988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print)	First: Pauline	Middle: Elizabeth	Last: Clark	2a. DATE OF DEATH: Month Oct. Day 20, Year 72	2b. HOUR: 5:50 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Aug. 26, 1914	6. AGE (In years last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife,	12b. KIND OF BUSINESS OR INDUSTRY: Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Ridgeley,	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Rt. # 1 Along St. Rt. # 28		
14. FATHER'S NAME First: Jacob	Middle: --	Last: Martin	15. MOTHER'S MAIDEN NAME First: Mollie	Middle: --	Last: Butcher	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown): No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Mr. George E. Clark Rt. # 1 Ridgeley, W. Va.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchogenic Lung Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Year

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): 1621

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. Espina	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 10/23/72	
22d. PHYSICIAN'S NAME (Type): R. R. Espina, M. D.	22e. ADDRESS: 924 Seton Dr. Cumberland, Md. 21502					

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/23/72	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 202 Greene St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 26 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14987

14989

1. DECEASED-NAME (Type or print) First: JOHN Middle: L. Last: CLISE

2a. DATE OF DEATH Month: 10 Day: 25 Year: 72

2b. HOUR: 2:40 M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: SEPT. 24, 1911

6. AGE (In years last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): MD.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): SUPERVISOR GLASS

12b. KIND OF BUSINESS OR INDUSTRY: CO.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: FROSTBURG

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 54 HAWTHORNE DRIVE

14. FATHER'S NAME First: JOHN Middle: L. Last: CLISE

15. MOTHER'S MAIDEN NAME First: BRIDGET Middle: Last: NOLAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 217-10-5030

17. INFORMANT Address: MRS. LAURA CLISE, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1978 IMMEDIATE CAUSE (a) Metastatic adenocarcinoma to the Liver
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10-11, 1972, to 10-25, 1972, that (I) (we) last saw the deceased alive on 10-25 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Werner Beck M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 27 Oct 1972

22d. PHYSICIAN'S NAME (Type): DR. W. BECK

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 10-27-1972

23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK

23d. LOCATION (City or Town) (County) (State): FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS: DURST FUNERAL HOME, FROST AVE., FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: OCT 30 1972

25b. REGISTRAR'S SIGNATURE: Audrey M. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH - 16 3/72 25M (VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14988 — 14990

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 BOM (VR A19-44)

1. DECEASED-NAME (Type or print): First MARY; Middle Elizabeth; Last M COSNER
2a. DATE OF DEATH: Month OCTOBER; Day 28; Year 72
2b. HOUR: 10:30A M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Sept. 7, 1900
6. AGE (In years last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): W. Va.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Waitress
12b. KIND OF BUSINESS OR INDUSTRY: Restaurant
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 137 Pennsylvania Ave.
14. FATHER'S NAME: First John; Middle Mc; Last Donald
15. MOTHER'S MAIDEN NAME: First Alberta; Middle L.; Lost White
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Josephine Wilson, Address Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1978
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June, 1972, to Oct 28, 1972, that (I) (we) last saw the deceased alive on Oct 25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/31/72
22d. PHYSICIAN'S NAME (Type): Dr. Blane Schindler, M.D.
22e. ADDRESS: 43 Green St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 31, 1972
23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR: James F. Scarpelli
ADDRESS: Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: NOV 6 1972
25b. REGISTRAR'S SIGNATURE: Sidney [illegible]

1

14989

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14991

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARY	SUSAN	CORLEY	10	8	1972	5:43 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	Cau.	4/13/11	61 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W.Va.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cresaptown	YES [ ] NO [X]	Box 206 Meadowview Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Toliver	--	Jewell	Mary	Ellen	Higgs

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No,	None	J. Paul Corley Box 206 Meadowview Dr. Cresaptown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ventricular fibrillation + tachycardia	20 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Right upper + lower lobe, pneumonitis severe	several days
DUE TO, OR AS A CONSEQUENCE OF (c)	Chronic Pulmonary Bullous Emphysema	years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebral vascular complication + Paralytic Ileus secondary to Pulm. Inflammation

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [✓]	

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / CONTRIBUTING	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospitol) attended the deceased from Oct 7, 19___, to Oct 8, 1972, that (I) (we) last saw the deceased alive on Oct 8 1972, and that in (my) (aur) apinion death occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Richard Schindler M.D.	[✓]	[ ]	[ ]	Oct, 10, 1972

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Richard E. Schindler, M.D.	69 Greene St Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/11/72	LYBARGER	Hyndman, Bedford, Penna.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md.	OCT 16 1972	Sidney L. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14990

14992

1. DECEASED-NAME (Type or print) First: JOHN. Middle: L. Last: CRONE	2a. DATE OF DEATH Month: Oct. Day: 6 Year: 1972	2b. HOUR: 10:30 P.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 5/04/98	6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CUMBERLAND NURSING CENTER	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Trackman	12b. KIND OF BUSINESS OR INDUSTRY: Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. Va.	13b. COUNTY: Morgan	13c. CITY OR TOWN: Sleepy Creek	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
			13e. STREET AND NUMBER: None
14. FATHER'S NAME First: CHARLES Middle: Last: CRONE		15. MOTHER'S MAIDEN NAME First: DORA Middle: BELLE Last: Albright	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 235-80-3629	17. INFORMANT: MRS CHARLES SPRIGGS	Address RT. II BERKLEY SPRINGS, W.VA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 min ?

DUE TO, OR AS A CONSEQUENCE OF (b): Advanced age VD — 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE

19a. DATE OF OPERATION: ✓	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: ✓	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓
21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ✓	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓	21f. LOCATION Street or R.F.D. No. ✓ City or Town County State	

22o. **I certify** that (I) (this hospital) attended the deceased from July, 1970, to 10-6, 1972, that (I) (we) last saw the deceased alive on 10-5 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin M. Rothstein DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-7-72		
22d. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN	22e. ADDRESS: 48 BROADWAY — FROSTBURG MD 21532		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 9, 1972	23c. NAME OF CEMETERY OR CREMATORY: Sphor's Crossroad Cem.	23d. LOCATION (City or Town) (County) (State): Berkley Springs, W. Va.
24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md.	ADDRESS	25o. REC'D BY REGISTRAR DATE: OCT 17 1972	25b. REGISTRAR'S SIGNATURE: Audrey H. Norton

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

14991

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14993

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month	Day	Year	2b. HOUR
Wilma	Martha	Crowe	Oct.	18,	1972	9.A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Female	White	June 14, 1893	79 YRS.					Oct.	18	1972	10.00 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
~~Bohark~~ Eckhart	Parkersburg Road	Domestic	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Barton	YES ☒ NO ☐	Legislative Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles F.		Broadwater	Senie	F.	Duckworth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no			Cecil A. Crowe	Barton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22b. DATE SIGNED 10/18/72

ADDRESS(Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/21/72	Rest Lawn Mem. Gardens	LaVale Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Earl Beal	Westernport, Md	OCT 27 1972	Sidney M. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
8M-1/70

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14992

14994

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
SUSAN	E.	CRUMP	10 6 72	12:55P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	OCT. 12, 1911	60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	TEXTILE	CELANESE CORP.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	MT. SAVAGE	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JAMES		MULLIGAN	ELIZABETH		HINER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-07-6177	MISS ALICE MULLIGAN, MT. SAVAGE, MD. 21545

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral embolism. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

398X

DUE TO, OR AS A CONSEQUENCE OF

(b) Rheumatic heartdisease. Artificial m. valve.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/ , 19 72, to 10/6 , 19 72, that (I) (we) last saw the deceased alive on 10/6 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	MD DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
P B Palmer	MD	☑	☐	☐	10/8/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
P.B. HACMOS	302 Schlaysl. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-10-1972	REST LAWN MEMORIAL PARK	LAVALE, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR., FROSTBURG, MD. 21532	OCT 11 1972	Audrey H. Norton

DHMH-16 1/71 30M (VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

14993 — 14995

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M (VR A15 (4))

	First	Middle	Last
1. DECEASED-NAME (Type or print)	Lola	Eleanor	Davis

2a. DATE OF DEATH: Month 10 Day 21 Year 72 — 2b. HOUR 10 30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	white	8/9/09	63 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Hwf	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland ~~Flintstone~~	YES [X] NO [X]	20 Rear Potomac Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Alec		Brown	Sally		Alkire

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No			Records-Sacred Heart Hospital, Cumberland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 180X Squamous Ca of Cervix T

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
X			

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type) DR. A. VALDES ~~EMMXXMDXX~~ — 22e. ADDRESS ALG. HTL., CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 24, 1972	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SCARPELLI FUNERAL HOME-VA. AVE., CUMB.	OCT 26 1972	Richard L Norton

FOR STATE HEALTH DEPT.

14994

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14996

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First: JOHN	Middle: NELSON	Last: DAY	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year: 10-19-72	2b. HOUR: 11:55 PM		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-15-96	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year: October 19, 1972	2d. HOUR: 11:55 P
7a. BIRTHPLACE (State or foreign country): W, Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Post Master	12b. KIND OF BUSINESS OR INDUSTRY: Post Office				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W, Va.	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Points	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rural			
14. FATHER'S NAME First: John	Middle: W.	Last: Day	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Rowzze		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): W. War I	16b. SOCIAL SECURITY NO.: 232-54-2643	17. INFORMANT ADDRESS: Mrs. Robert S. Haines, Points, W, Va.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4124

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): ASCV Disease — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: OCTOBER 19, 1972

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 22, 1972	23c. NAME OF CEMETERY OR CREMATORY: Branch Mt. Cemetery	23d. LOCATION (City or Town) (County) (State): Three Churches Hampshire W, Va.	
24. FUNERAL DIRECTOR: Keith S. Shaffer	ADDRESS: Romney, W, Va.	25a. REC'D BY REGISTRAR DATE: OCT 24 1972	25b. REGISTRAR'S SIGNATURE: Sidney M. Norton	

DHMH-17 1/71 10M
(VR A15ME (5))

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

14995 — 14997

1. DECEASED-NAME (Type or print): First RACHEL Middle SUSAN Last DAY
2a. DATE OF DEATH: Month 10 Day 16 Year 72
2b. HOUR: 12 M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: DECEMBER 29, 1906
6. AGE (In years last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MD.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: FROSTBURG
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): FBG COMMUNITY HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEKEEPER
12b. KIND OF BUSINESS OR INDUSTRY: CHURCH RECTORY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: FROSTBURG
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 88 MESHACH FROST VILLAGE
14. FATHER'S NAME First CLARENCE Middle Last RALEY
15. MOTHER'S MAIDEN NAME First LAURA Middle Last MCKENZIE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 213-22-3114A
17. INFORMANT: MR. CHARLES L. DAY, Address: FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CVA
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 10/15 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Henry Vicini DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): HENRY VICINI, M.D.
22e. ADDRESS: FBG COMMUNITY HOSP., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-19-1972
23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): FROSTBURG, ALLEGANY, MD.
24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST SR., FROSTBURG, MD. 21532
25a. REC'D BY REGISTRAR DATE: OCT 20 1972
25b. REGISTRAR'S SIGNATURE: Audrey H. Norton

VR A15 (4) 45M - 1X697

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14996

14998

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-A15 (4) 25m-1/70

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EFFie	May	DeHaven	October	23	1972	12 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
7	W	7/27/79	93 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Shanghi, W. Va	U. S.	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
90 Cumberland	Cumberland Nursing & Convalescent Center	Housewife,	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
01 Md.	Allegany	Cumberland	YES [ ] NO [X]	Rt. 2 DeHaven Road.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
1 John		DeHaven	Emily	Catherine	Brannon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No,		212-54-5873	Mrs. Phyllis C. Gulick 4110 3rd Rd.	Arlington, Va. 22203

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4123 IMMEDIATE CAUSE (a) Not known — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Old age. IHD.

2

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [✓]	

21a. ACCIDENT WAS / OR CONTRIBUTING / (If either, notify medical examiner)	UNDERLYING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 3/27, 19 70, to 10/23, 19 72, that (I) (we) last saw the deceased alive on 10/16 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	MD DEGREE	ATTENDING PHYS. [✓]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED
P B Halmos					10/27/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
P.B. HALMOS	20 Schlegel St. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/26/72	Rose Hill Cemetery	Hagerstown, Washington, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	OCT 27 1972	Sidney [illegible]

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/[illegible] 10M
(VR A15ME (5))

14997

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14999

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year	2b. HOUR
DAIRIE	MAE	DOLLY	10-31-72	6a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
FEMALE	WHITE	DEC. 31, 1884	87 YRS.					October 31, 1972	11a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. VA.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FLINTSTONE	STAR ROUTE	MINISTER	CHURCH

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FLINTSTONE		ROUTE 2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ISAIAH		SITES	SARAH		MALLOW

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	217 28 7795A	ZERA M. BARNES	STAR ROUTE FLINTSTONE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED October 31, 1972

ADDRESS (Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	NOV. 4, 1972	DOLLY CEMETERY	FLINTSTONE, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
WILLIAM G. KIGHT	CUMBERLAND, MD.	NOV 3 1972	Sidney H. Norton

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14998

15000

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MV Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	PEARL	NANNIE	DRENNING

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Oct. Day 13 Year 1972 — 2b. HOUR 8:30a

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Female	White	March 13, 1903	69 YRS.				

2c. DATE PRONOUNCED DEAD: Month Oct. Day 13 Year 1972 — 2d. HOUR 9:00a

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
West Virginia	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	50 Boone St.	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	50 Boone St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George		Whetzel	Mary	H.	Lewis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	220-58-0020	Charlotte Mudge	Cumberland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED Oct. 13, 1972

ADDRESS (Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 16, 1972	Rose Hill Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt 121 Memorial Ave., Cumb., Md.	OCT 17 1972	Nancy M. Norton

VR A15ME (S)
10M - 1/69

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14999

15001

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year	2b. HOUR
RUBEN	W.	EATON	10/3/1972	5 A.M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
MALE	WHITE	JULY 20, 1892	80 YRS.					OCT. 3 1972 19	5 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	DOA MEMORIAL HOSPITAL	CAR INSPECTOR	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	1411 FREDERICK STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
RUBEN		EATON	ELLA		VALLID

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	705 09 6680	MRS. BETTY LARGEANT CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109	IMMEDIATE CAUSE (a) CORONARY OCCLUSION	SUDDEN
	DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS	-------
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(St. & No., City, Town, or County) RT 9 CUMBERLAND, MD.

22b. DATE SIGNED OCT. 3, 1972

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	OCT. 5, 1972	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT CUMBERLAND, MD.	OCT 6 1972	Sidney H Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15000 — 15002

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MINNIE	I.	ELLIOTT	10 30 72	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	February 28, 1889	83 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	MEMORIAL HOSP.	Housekeeper- At Home	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Penna	Bedford	Bedford Valley		Route #3

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
(Unknown)			(Unknown)		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	177-32-8940	Mrs. Ruth Zembower	Rt #3 Bedford Road Cumberland, Md

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Heart Block. Congestive heart failure	
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary art. d.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

4123
Conditions, if any, which gave rise to immediate cause (a), stoting the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 10/18, 1972, to 10/30, 1972 that (I) (we) last saw the deceased alive on 10/3- 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
T R Fulmer	MD				10/31/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
T R FULMER	302 Schley st. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/3/72	Bethel Cemetery	Centerville Bedford Penna

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	NOV 3 1972	Sidney H Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15001 — 15003

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First MILDRED; Middle Flossie; Last ENSMINGER
2a. DATE OF DEATH: Month OCTOBER; Day 14; Year 1972
2b. HOUR: 12:40 PM
3. SEX: Female
4. RACE: WHITE
5. DATE OF BIRTH: JAN 17, 1904
6. AGE (In years last birthday): 68 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (State or foreign country): CUMBERLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND MD
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): LIONS MANOR NURSING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED SECRETARY
12b. KIND OF BUSINESS OR INDUSTRY: Food Factory
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 226 PEAR ST. CITY
14. FATHER'S NAME: First Jacob; Middle Hunter; Last Shinholt
15. MOTHER'S MAIDEN NAME: First Lulu; Middle L.; Last Briggs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-05-5429
17. INFORMANT: Address: LIONS MANOR N.H. OFFICE, CUMBERLAND MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
201X
IMMEDIATE CAUSE (a): Acute Cardiac failure — Few minutes.
DUE TO, OR AS A CONSEQUENCE OF
(b): Severe Secondary anemia — Few months.
DUE TO, OR AS A CONSEQUENCE OF
(c): Hodgkins Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Early Bowtal carcinoma

19a. DATE OF OPERATION: 7-28-72
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Hodgkins Disease
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Sep. 25, 1972, to Oct 14, 1972, that (I) (we) last saw the deceased alive on Oct 14 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A Topper
DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. DATE SIGNED: 10-16-72
22d. PHYSICIAN'S NAME (Type): John A Topper MD
22e. ADDRESS: Hyndman Pa

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/17/72
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.
24. FUNERAL DIRECTOR: H. Wayne George
ADDRESS: 202 Greene St. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 19 1972
25b. REGISTRAR'S SIGNATURE: Archaph Norton

DHMH - 16 3/72 25M
(VR A15 (4))

FOR STATE HEALTH DEPT.

15002

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15004

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner - Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Stelmer Middle: RAY Last: FLANAGAN					2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Doy Yeor: X 10-15-72		2b. HOUR: 1:20 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-18-24	6. AGE (In years last birthday): 47 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Doy Yeor: October 15, 1972	2d. HOUR: 2p M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒				9. COUNTY OF DEATH: Allegany Md.	
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Memorial Hospital-DOA				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mechanist Helper		12b. KIND OF BUSINESS OR INDUSTRY: Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Allegany	13c. CITY OR TOWN: Oldtown	13d. INSIDE CITY LIMITS? YES ☐ NO ☒		13e. STREET AND NUMBER: RFD #1		
14. FATHER'S NAME First Middle Lost: William E. Flanagan					15. MOTHER'S MAIDEN NAME First Middle Lost: Rada Mick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.: 235-22-2850			17. INFORMANT ADDRESS: William R. Flanagan, Ridgeley, W.Va. Son		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Skull Fracture; Crushed Chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): (Automobile Accident)

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M.: 1:20 P.M. 10-15-72	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.): Driver One Car Accident
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Rt. #51 2½ miles	21f. LOCATION Street or R.F.D. No. City or Town County Stote: west of Oldtown, Allegany, Maryland

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☒, Inspectian ☒ Inquiry ☒ and in my opinian death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: October 15, 1972

ADDRESS(Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 18, 1972	23c. NAME OF CEMETERY OR CREMATORY: Parsons City Cemetery	23d. LOCATION (City or Town) (County) (Stote): Parsons, W. Va.	
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE: OCT 19 1972	25b. REGISTRAR'S SIGNATURE: Sidney M Norton	

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15003 — 15005

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
CHARLES	WILLIAM	FLEMING	10 15 72

2b. HOUR: 11:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	Sept. 5, 1886	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W, Va.	U. S.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Farmer	Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W, Va.	Mineral	Burlington	YES ☐ NO ☒	Rural

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David		Fleming	Belle		Huffman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	236-58-0969	Cecil Hartman, Rt. 1, Burlington, W, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO, OR AS A CONSEQUENCE OF

(b) Syphilis — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George Breja MD		☒	☐	☐	16 Oct 72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George Breja M.D.	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/18/72	High Cemetery	Junction Hampshire W, Va.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Keith S. Shaffer, Romney, W, Va.	OCT 20 1972	Sidney H. Norton

15004

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed locally in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
AGNES	S	FOOTE	10	1st.	1972	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	4/18/1888	84 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MD.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Community	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing		Florida Way

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas		Dick	Mary		Schuyler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Felix Foote (Husband)	Lonadoning, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic debilitation — weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Primary Ca of stomach with Carcinomatosis

X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** thot (I) (this hospitol) ottended the deceosed from _____, 19 58, to Oct. 1, 19 1972 thot (I) (we) lost sow the deceosed olive on 9-30 1972 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above. (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L R Miles MD	MD	[X]	[ ]	[ ]	10-2-72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L R MILES JR MD	LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/3/1972	Sunset Memorial Park	Cumberland, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	OCT 4 1972	Nancy H Norton

DHMH - 16 3/72 25M
(VR A15 (4))

1

FOR STATE HEALTH DEPT.

15005

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15007

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Elizabeth		Footen

2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ Month Oct. Day 14, Year 1972 — 2b. HOUR 1:00 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Female	White	June 26, 1907	65 YRS.				

2c. DATE PRONOUNCED DEAD Month Oct. Day 15, Year 1972 — 2d. HOUR 4:00 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Maryland	U. S. A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	640 Washington St.	Ret. Secretary	Navy Dept. U. S. Gov't

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES ☒ NO ☐	640 Washington St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frederick	C.	Hardman	Agatha	B.	Mason

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No,	578-05-1062	Mrs. Joseph J. Burkey 715 Gephart Dr. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b). and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factary, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that I taak charge of the remains described above, held an Autapsy ☒, Inspectian ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒☒
ADDRESS(Street, city, town, or county) Rt. # 9 Cumberland, Md.

22b. DATE SIGNED 10/15/72

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	10/18/72	St. Patrick's Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	OCT 20 1972	Sidney M. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15006 — 15008

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First / Middle / Last	BEATRICE (Adgauskas) GHOST	2a. DATE OF DEATH Month / Day / Year	10 / 7 / 72
2b. HOUR	2:30 AM		
3. SEX	female	4. RACE	White
5. DATE OF BIRTH	Apr. 18, 1897	6. AGE (In years last birthday)	75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	W.Va.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. COUNTY OF DEATH	~~Allegheny~~ Allegany Md.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	Home
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE	W.Va.	13b. COUNTY	Tucker
13c. CITY OR TOWN	Thomas	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	Euclid		
14. FATHER'S NAME First / Middle / Last	George W. Stump	15. MOTHER'S MAIDEN NAME First / Middle / Last	Priscilla Hardesty
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	16b. SOCIAL SECURITY NO.	233-96-9327
17. INFORMANT	Paul R. Hart	Address	621 Queen St Cumberland Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS (If either, natify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/2/72, 19__ to 10/7/72, 19__, that (I) (we) last saw the deceased alive on 10/6/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 10/7/72

22d. PHYSICIAN'S NAME (Type) W.G.Fiscus — 22e. ADDRESS Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Burial 10/9/72	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.	23d. LOCATION (City or Town) (County) (State)	Thomas, Tucker, W.Va.
24. FUNERAL DIRECTOR	J.D.D.Duncan	ADDRESS	Thomas, W.Va. 26292	
25a. REC'D BY REGISTRAR DATE	OCT 13 1972	25b. REGISTRAR'S SIGNATURE	Sidney H. Norton	

15007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

16713

1. DECEASED-NAME (Type or print)	First: MARY	Middle: May	Last: GIFFORD	2a. DATE OF DEATH Month: 10 Day: 25 Year: 72	2b. HOUR: 6:15P M
3. SEX: F	4. RACE: White	5. DATE OF BIRTH: 5-1-1885	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Watchwoman	12b. KIND OF BUSINESS OR INDUSTRY: B&O		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. Va.	13b. COUNTY	13c. CITY OR TOWN: Ridgeley	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rt. # 1	
14. FATHER'S NAME First: Jacob	Middle: A.	Last: Smith	15. MOTHER'S MAIDEN NAME First: Alice	Middle:	Last: Birch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 705-05-1725	17. INFORMANT: Thomas Smith Gifford	Address: Ridgeley, W. Va.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — Approximate interval between onset and death: 2 wk

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary artery dis — unk

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — unk

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Previous episodes of Congestive Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11-2-72	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-28-72	23c. NAME OF CEMETERY OR CREMATORY: Terra Alta Cemetery	23d. LOCATION (City or Town) (County) (State): Terra Alta, Preston, W.Va.	
24. FUNERAL DIRECTOR: Glen K. Whitehair	ADDRESS: 26764 Terra Alta, W.Va.	25a. REC'D BY REGISTRAR DATE: NOV 14 1972	25b. REGISTRAR'S SIGNATURE: Sidney Norton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15008 — 15009

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First	Middle	Last
	LYDIA	VICTORIA	HAINES

2a. DATE OF DEATH: Month 10 Day 25 Year 72 — 2b. HOUR: 1:40 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	Jan. 13, 1908	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	U. S. A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	MEMORIAL Hosp.	Examiner	Celanese

13a. USUAL RESIDENCE (Where deceased lived / if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. Va.	Mineral	Ridgeley,	YES ☒ NO ☐	5 Mineral St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	E.	Ellifritz	Nona	B.	Sears

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No.	214-07-6330	Mrs. Floyd D. Powell, Jr. 5 Mineral St.	Ridgeley, W. Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Anuria	3 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Diabetes Mellitus	years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS (If either, notify medical examiner)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.)
UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June, 1954, to 10/25, 1972 that (I) (we) last saw the deceased alive on 10/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Blane M. Schindler M.D.	M.D.	☒	☐	☐	10/26/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Blane M. Schindler, M. D.	43 Greene St. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/28/72	Biser Cemetery	Knobley Rd. Mineral W. Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George	202 Greene St. Cumberland, Md.	OCT 30 1972	Sidney H. Norton

1

FOR STATE HEALTH DEPT.

15009

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15010

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Complete Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours of death.

	First	Middle	Last
1. DECEASED NAME (Type or Print)	Carl	Louis	Hallberg

2a. DATE KNOWN OF DEATH ESTIMATED ☐ — Month Oct. Day 13 Year 1972 — 2b. HOUR 5A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
Male	White	Jan. 31, 1918.	54 YRS.				

2c. DATE PRONOUNCED DEAD Month Oct. Day 13 Year 1972 — 2d. HOUR 5A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Mass.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA Sacred Heart Hospital	Drafting Dept.	Hercules Inc.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W.Va.	Mineral	Short Gap	YES ☐ NO ☒	Route 1

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Carl Hallberg	Anna Hallberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	War II	022-01-8933	Mrs. Anna Hallberg, Short Gap, W.Va. Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4109	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	------
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE, M.D. Benedict Skitarelic

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Oct. 13, 1972

ADDRESS(Street, city, town, or county) Rt. 9 Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 16, 1972	Mt. Wollaston Cemetery	Quincy, Mass.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 19 1972	Sidney H. Norton

DHMH-17 1/71 10M
(VR A15ME (5))

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15011

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Jesse	Brook	Heavner	10-2-72	4:10p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	11-8-1912	59 YRS.					October 2, 1972	4:10p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
W.Va.	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital-DOA	Textile	Celanese

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [ ] NO [X]	R.D.#6 Box 248

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Albert		Heavner	Bessie		Hyre

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-10-4380	Mrs. Audrey Heavner	RD #6 Box 248 Cumberland, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED October 2, 1972

ADDRESS (Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/5/72	Hillcrest Burial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Home, Cumberland, Md. 21502	OCT 5 1972	Audrey M Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15011

15012

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: EFFIE	Middle: GRACE G.	Last: HEBB	2a. DATE OF DEATH: Month 10 Day 13 Year 1972	2b. HOUR: 10:10 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Dec. 20, 1930	6. AGE (In years last birthday): 41 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): waitress & hsg.	12b. KIND OF BUSINESS OR INDUSTRY: Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland,	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 216 Ave. I. Potomac Park		
14. FATHER'S NAME: First James	Middle --	Last Snyder	15. MOTHER'S MAIDEN NAME: First Harriet	Middle --	Last Twigg	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-30-9884	17. INFORMANT: Mr. Floyd Hebb	Address: 216 Ave. I. Potomac Park, Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma Nasopharynx — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(b): Hemorrhage — 24 h.

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 147X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify thot (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and thot in (my) (aur) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: George Breza M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/16/72

22d. PHYSICIAN'S NAME (Type): George M. Breza, M. D. — 22e. ADDRESS: 912 Seton Dr. Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/16/72	23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 202 Greene St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 19 1972	25b. REGISTRAR'S SIGNATURE: Llewellyn Norton	

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15012

15013

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
MAMIE	ROSE	HOOK	10 31 72	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	August 18, 1906	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
W. Va	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL	Former Employee- Mary's	Cleaners

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	1806 Holland Street

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Christopher		Martin	Margaret		Fout

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		220-10-7133	Wm M. Hook	1806 Holland Street Cumberland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ca of rectosigmoid & metastis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 mo
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1540

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Peritnitis due to tumor perforation of bowel

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
10/30/72	Pelvic tumor	YES ☐ NO ☒	

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 10/14, 19 72, to 10/31, 19 72 that (I) (we) last saw the deceased alive on 10/31 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Andrew Stasko MD		☒	☐	☐	11-1-72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. A. STASKO	401 DECATUR ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/3/72	Hillcrest Burial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
SILCOX, MERRITT FUN. SER. 404 DECATUR ST. CUMBERLAND, MD.	NOV 3 1972	Sidney M Norton

SILCOX, HERRITT FUN. SER. 404 DECATUR ST.
CUMBERLAND, MD.

DR. A. STOSKO 401 DECATUR ST., CUMBERLAND, MD.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15013

15014

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: LOTTIE	Middle: I.	Last: HYATT	2a. DATE OF DEATH Month: 10 Day: 6 Year: 72	2b. HOUR: 2:00P M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: March 1, 1886	6. AGE (In years last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penna.	13b. COUNTY: Bedford	13c. CITY OR TOWN: Hyndman	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D.# 1	
14. FATHER'S NAME First: Frank	Middle:	Last: Fisher	15. MOTHER'S MAIDEN NAME First: Mary	Middle:	Last: Fisher
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.: 164-50-6846	17. INFORMANT: Mr. Donald Hyatt	Address: R.D.# 1, Hyndman, Pa. 15545		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Overwhelming septicemia	10 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple abscesses of liver	4 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Pancreas gallbladder & pancreatitis	4 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

575X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 10/1, 1972, to 10/6, 1972, that (I) (we) last saw the deceased alive on 10/6 1972, and that in (my) (our) opinian death occurred on the date and haur and from the causes stated abave. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Thomas F Lewis M D	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/6/72	
22d. PHYSICIAN'S NAME (Type): DR. THOMAS F. LEWIS	22e. ADDRESS: CUMBERLAND, MD		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 9, 1972	23c. NAME OF CEMETERY OR CREMATORY: Jersey Cemetery	23d. LOCATION (City or Town): Confluence,	(County): Somerset, Pa. (State)
24. FUNERAL DIRECTOR: Silcox-Merritt Fun. Ser.	ADDRESS: 404 Decatur St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 10 1972	25b. REGISTRAR'S SIGNATURE: Sidney H Norton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15014

15015

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
HAZEL	A.	JAMES	OCTOBER 19, 1972	9:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	JULY 23, 1903	69 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH		
MD.	U.S.A.		ALLEGANY Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
FROSTBURG	FBG COMMUNITY HOSPITAL	HOUSEWIFE	OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER	
MD.	ALLEGANY	FROSTBURG		99 BROADWAY	
14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
RICHARD		ROBISON	ROSA		RAVENSCROFT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address	
NO		216-01-8798B	MR. THOMAS JAMES,	99 BROADWAY FROSTBURG, MD.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypertensive C-V disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO, OR AS A CONSEQUENCE OF

(b) Diabetes Mellitus — —

DUE TO, OR AS A CONSEQUENCE OF

(c) — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ] (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 6-6, 1965, to 10-19, 1972, that (I) (~~we~~) last saw the deceased alive on 10-19 1972, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE H.C. Diehl M.D. DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 10/21/72	
22d. PHYSICIAN'S NAME (Type) H.C. DIEHL, M.D.	22e. ADDRESS 39 WEST MAIN ST., FROSTBURG, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-22-1972	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR ADDRESS JOSEPH R. DURST SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE OCT 26 1972	25b. REGISTRAR'S SIGNATURE Lindsay M. Norton	

15014

HAZEL A. JAMES OCTOBER 15, 1912

FEMALE WHITE JULY 23, 1903 69

X

ID. U.S.A. ALLEGANY

PROSTBURG MED. COMMUNITY HOSPITAL HOUSEWIFE OWN HOME

MD. ALLEGANY PROSTBURG X 99 BROADWAY

RICHARD ROBISON NONA MAYNARDIER

99 BROADWAY

NO 214-01-8702B NE. THOMAS JAMES, PROSTBURG, MD.

X

H.G. DIEHL, M.D. 39 WEST MAIN ST., PROSTBURG, MD.

BURIAL 10-22-1972 PROSTBURG MEMORIAL PARK PROSTBURG, ALLEGANY, MD.

JOSEPH F. DURST SR., PROSTBURG, MD. 21532

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15015 — 15016

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Lutie	Middle: Mae	Last: Jones	2a. DATE OF DEATH: Oct. Month 11, Day 72 Year
2b. HOUR: 4:15 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Nov. 3, 1883	6. AGE (In years last birthday): 88 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 12 So. Lee St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife,	12b. KIND OF BUSINESS OR INDUSTRY: Own home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland,	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 12 So. Lee St.			
14. FATHER'S NAME First: John	Middle: W.	Last: Buchanan	15. MOTHER'S MAIDEN NAME First: Sarah / Middle: -- / Last: Clauson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Cumb. Md. Mrs. John J. Reinhard, Jr. 17 Prospect Sq.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebro-vascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

DUE TO, OR AS A CONSEQUENCE OF (b): ACVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5 - 27, 19 68, to 10 - 11, 19 72, that (I) (we) last saw the deceased alive on 10 - 10 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph W. Ballin M. D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-12-72	
22d. PHYSICIAN'S NAME (Type): Ralph W. Ballin, M. D.	22e. ADDRESS: 51 Greene St. Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/14/72	23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Mausoleum	23d. LOCATION (City or Town) (County) (State): Baltimore Baltimore Md.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: 202 Greene St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 16 1972	25b. REGISTRAR'S SIGNATURE: Sidney J. Norton

VR A15 (4) 30M REV. 1/68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15016 15017

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

	First	Middle	Last			
1. DECEASED-NAME (Type or print)	THOMAS	H	KAYLOR	2a. DATE OF DEATH Month	Day	Year: 10 18 72
2b. HOUR	M					

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	Mar. 4th 1894	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
W. Va.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED B. & O. RR	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W.VA.	MORGAN	PAW PAW	YES [X] NO [ ]	c/o POSTMASTER

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
THOMAS Wm KAYLOR	SARAH FRANCE MILLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT c/o Postmaster Address
NO		SARAH R. KAYLOR, PAW PAW, W. VA. 25434

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	4339 Bronchopneumonia, bilateral	5 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Right hemiplegia	5 wks
DUE TO, OR AS A CONSEQUENCE OF (c)	Left Cerebral infarction - Cerebral Thrombosis	5 wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerotic Cardiovascular disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING [ ] CAUSE OF DEATH [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to 10/18, 19 72, that (I) (we) last saw the deceased alive on 10/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
S.G. Weisman MD		[X]	[ ]	[ ]	10/19/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
S.G.WEISMAN, M.D.	59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/21/1972	CAMP HILL	PAW PAW, W.VA. (MORGAN)

24. FUNERAL DIRECTOR	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOHNSON'S FUNERAL HOME, 208 WASHINGTON ST. BERKELEY SPRINGS, W. VA.	OCT 24 1972	Sidney Horton

DHMH - 163/72/25M
(VR A15 (4))

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

15017

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15018

1. DECEASED-NAME (Type or Print)	First: Ellsworth	Middle: F.	Last: Kitzmiller	2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐	Month: 10 Day: 28 Year: 72	2b. HOUR: 8.30 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 12/6/1933	6. AGE (In years last birthday): 38 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 10 Day 28 Year 1972 — 2d. HOUR: 8:30 PM

7a. BIRTHPLACE (State or foreign country): Allegany

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Frostburg

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Community Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Unemployed

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md

13b. COUNTY: Allegany

13c. CITY OR TOWN: Midland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: Railroad Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ossie		Kitzmiller	May		Warnick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Edith Kitzmiller "Wife" ADDRESS: Midland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemmorage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 HRS.

4310

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Hypertention

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: 10/28/1972

ADDRESS (Street, city, town, or County): Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	10/31/72	Memorial Park	Frostburg	A.	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	NOV 3 1972	Evelyn Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15018 · 15019

1. DECEASED-NAME (Type or print): First MINNIE Middle BELLE Last KREIGER
2a. DATE OF DEATH: Month 10 Day 23 Year 72
2b. HOUR: 9:06 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: April 2, 1897
6. AGE (In years last birthday) 75 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country) W. Va.
7b. CITIZEN OF WHAT COUNTRY? U. S. A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland,
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic,
12b. KIND OF BUSINESS OR INDUSTRY: Private Homes
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland
13b. COUNTY Allegany
13c. CITY OR TOWN: Cumberland,
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 21 Potomac St.
14. FATHER'S NAME First Harrison Middle -- Last Valentine
15. MOTHER'S MAIDEN NAME First Anna Middle L. Last Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No, (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT Address: Mr. Gilbert H. Sisk Rt. # 1 Ridgeley, W. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1530 IMMEDIATE CAUSE (a) pseudomyxoma of peritoneum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF
(b) cancer of coecum — 2 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify thot (I) (this hospitol) attended the deceased from 9-10, 1972, to 10-23, 1972, thot (I) (we) last sow the deceased olive on 10-23 19 72, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE: G Brings DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-24-72
22d. PHYSICIAN'S NAME (Type): DR. L. BRINGS
22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/26/72
23c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery
23d. LOCATION (City or Town) (County) (Stote): Nr. Ridgeley, Mineral W. Va.
24. FUNERAL DIRECTOR H. Wayne George ADDRESS: GEORGE'S FUNERAL HOME, 202 GREENE, CUMB. MD.
25a. REC'D BY REGISTRAR DATE OCT 27 1972
25b. REGISTRAR'S SIGNATURE: Sidney Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH - 16 3/72 25M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15019 — 15020

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JANET	Middle:	Last: LEE	2a. DATE OF DEATH Month: Oct	Day: 2	Year: 1972	2b. HOUR: 2:15 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 03/27/84	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): CUMBERLAND NURSING CENTER 512 WINIFRED RD.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LONACONING	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 30 FLORIDA WAY.			
14. FATHER'S NAME First: DANIEL	Middle:	Last: TIMMEY	15. MOTHER'S MAIDEN NAME First: Ellen	Middle:	Last: Lindsy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 164-10-3060	17. INFORMANT: MR. JOSEPH LEE,	Address: BALTIMORE, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Adenocarcinoma of Uterus

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Advanced ACVD - Senile reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE	✓	YES ☐ NO ☒	✓

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
☐	☐	✓	✓

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	✓	✓			

22a. **I certify** that (I) (this hospital) attended the deceased from July, 1970, to 10-2, 1972, that (I) (we) last saw the deceased alive on 10-1 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Martin Rothstein	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	10/2/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN M.D.	48 BROADWAY - FROSTBURG - MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/5/1972	Laurel Hill Cemetery	Moscow, Md. 21521

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	OCT 5 1972	Sidney N. Norton

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15020

15022

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: OLIVER	Middle: ROY	Last: LEPLEY	2a. DATE OF DEATH Month: 10 Day: 13 Year: 72	2b. HOUR: 6:35 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: April 6, 1907	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Security Of.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Trost Ave. Extended		
14. FATHER'S NAME First Middle Last: Dalton B. Lepley	15. MOTHER'S MAIDEN NAME First Middle Last: Cora A. Mc Coy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): War II	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Mrs. Ellen Lepley, Cumberland, Md Wife				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b): Hemorrhagic Arteriosclerotic Heart
DUE TO, OR AS A CONSEQUENCE OF (c): Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4123
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days / years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June 1, 19 72 to Oct 13, 19 72 that (I) (we) last saw the deceased alive on Oct 12 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10/14/72
22d. PHYSICIAN'S NAME (Type): Dr. Blane M. Schindler
22e. ADDRESS: Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 15, 1972	23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Alleg. Md.	
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 19 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton		

DHMH-16 1/71 30M
(VR A15 41)

1

FOR STATE HEALTH DEPT.

15021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15023

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
ROBERT	CHRISTIAN	LEPLEY	☒	10-	30-	1972	1:30pm

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	White	6/15/72	YRS	4	15			October	30,	1972	1:30pm

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	909 Bedford St.--DOA		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	LaVale	YES ☐ NO ☒	551 Henry Drive (LaVale)

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Robert	G	Lepley	Nancy		Knippenberg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Robert G. Lepley	551 Henry Drive LaVale, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3786	IMMEDIATE CAUSE (a) Cerebral Edema, Marked	Hours
	DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhage of Choroid Plexus,	"
	DUE TO, OR AS A CONSEQUENCE OF (c) right ventricle	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Congentital stenosis of aqueduct of Sylvius

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED October 30, 1972

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	11/1/72	Rest Lawn Memorial Gardens	LaVale Allegany Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md	21502	NOV 2 1972	Sidney M Norton

DHMH-17 1/71 10M
(VR A15ME)

15022

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15024

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEO	A.	LOGSDON	OCTOBER 20, 1972	8:15 a. M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	MAY 15, 1906	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol give street address)	12a. USUAL OCCUPATION (Kind af wark done during most of warking life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	FBG COMMUNITY HOSPITAL	SCHOOL BUS OPERATOR	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	MT. SAVAGE	YES [ ] NO [X]	ROUTE 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ALBERT		LOGSDON	NORA		PRICE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-32-2861	MRS. MARY E. LOGSDON, MOUNT SAVAGE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) A-S-C-V-D

DUE TO, OR AS A CONSEQUENCE OF (b) Complete Heart Block.

DUE TO, OR AS A CONSEQUENCE OF (c) Moderate Hypertension

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 4122

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, natify medical examiner) UNDERLYING [ ] CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture af injury in Part 1 ar Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City ar Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 4-10, 1970, to 10-20, 1972, that (I) (~~we~~) last saw the deceased alive an 10-20 1972, and that in (my) (~~our~~) apinion death accurred an the date and haur and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H.C. Diehl, M.D.		[X]	[ ]	[ ]	10/21/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H.C. DIEHL, M.D.	39 WEST MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-23-1972	ST. PATRICKS CEMETERY	MT. SAVAGE, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR., FROSTBURG, MD. 21532	OCT 26 1972	Sidney H. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be stored with the State Dept of Health and Mental Hygiene prior to burial, cremation, ar removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15023 15025

1. DECEASED-NAME (Type or print): First ALVIN Middle E. Last LOWERY
2a. DATE OF DEATH: Month 10 Day 21 Year 72
2b. HOUR: 11:45P
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: April 24, 1904
6. AGE (In years last birthday): 68 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): B&O Employee
12b. KIND OF BUSINESS OR INDUSTRY: RR
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pennsylvania
13b. COUNTY: Bedford
13c. CITY OR TOWN: Hyndman
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: RD#1 15545
14. FATHER'S NAME First Noah Middle Lowery Last
15. MOTHER'S MAIDEN NAME First Annie Middle Clites Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: A217-10-6605
17. INFORMANT: Mrs. Alvin E. Lowery, Hyndman, P. RD#1 Address

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b): Amyotrophic Lateral Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
3480
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10/14/72, 19___, to 10/21, 1972, that (I) (we) last saw the deceased alive on 10/21 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P B Aalmos MD DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 10/22/72
22d. PHYSICIAN'S NAME (Type): P. B. AALMOS
22e. ADDRESS: 302 Schlegel. Cumberland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: October 24, 1972
23c. NAME OF CEMETERY OR CREMATORY: Peeter Cemetery
23d. LOCATION (City or Town) (County) (State): Hyndman, Bedford County, Pa.

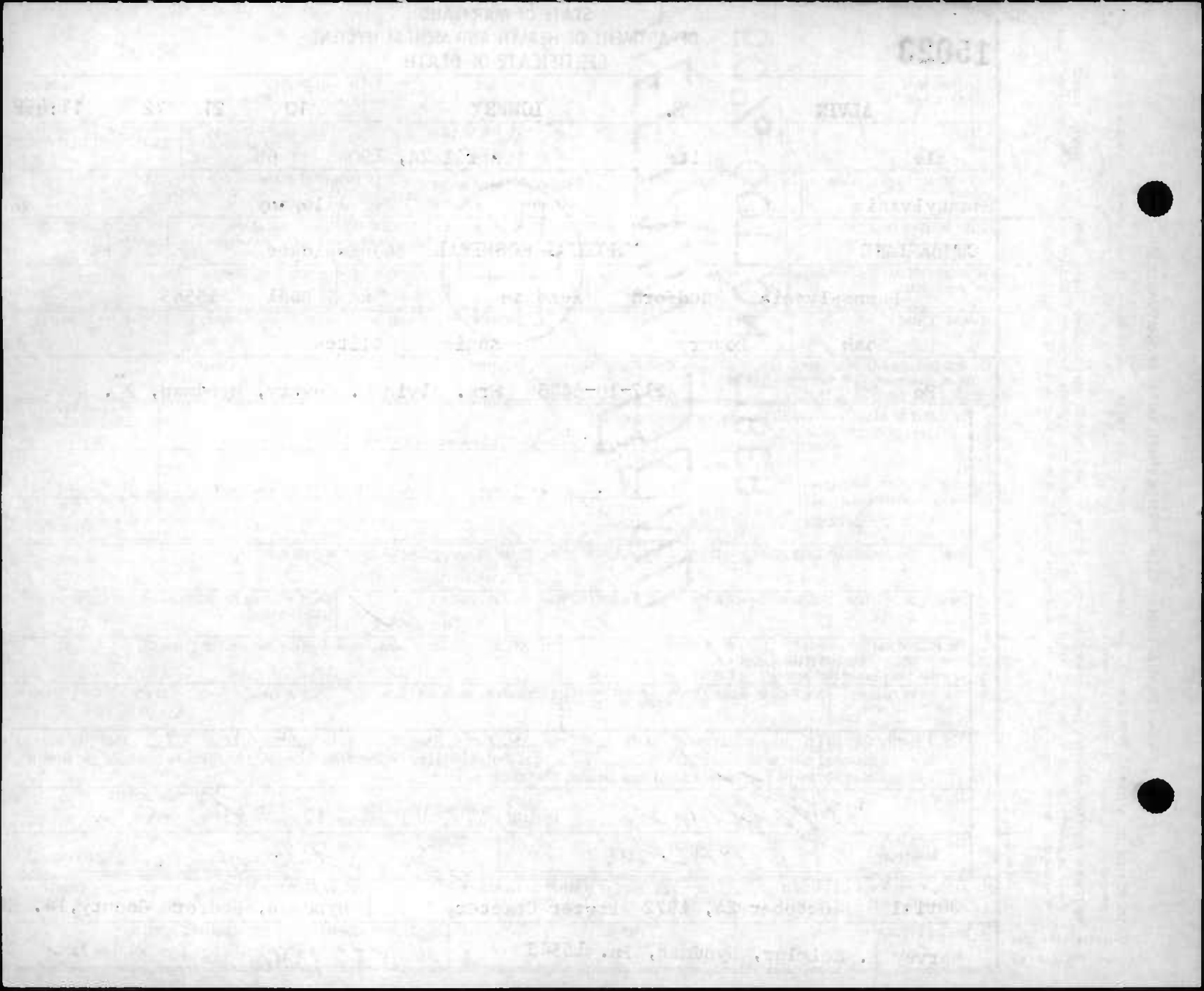
24. FUNERAL DIRECTOR ADDRESS: Harvey H. Zeigler, Hyndman, Pa. 15545
25a. REC'D BY REGISTRAR DATE: OCT 27 1972
25b. REGISTRAR'S SIGNATURE: Sidney H. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15024 — 15026

1. DECEASED-NAME (Type or print): First LARRY; Middle E.; Last MALONE
2a. DATE OF DEATH: Month 10- Day 18-72 Year
2b. HOUR: 11:10 P
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Aug. 18, 1946
6. AGE (In years last birthday): 26 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Postal Clerk
12b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 1017 Penhurst St.
14. FATHER'S NAME First Middle Last: Lantz E. Malone
15. MOTHER'S MAIDEN NAME First Middle Last: Elizabeth B. Frost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes Viet Nam
16b. SOCIAL SECURITY NO.: 218-48-9310
17. INFORMANT Address: Karen Malone, Cumberland, Md. Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: June 70
DUE TO, OR AS A CONSEQUENCE OF
(b) Embryonal Cell Carcinoma of the Testicle — June 70
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
186X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10-18-72 19___, to 10-18-72 19___, that (I) (~~we~~) last saw the deceased alive on 10-18-72 19___, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE: G.O. Himmelwright, M.D. per William James, M.D. — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10-21-72
22d. PHYSICIAN'S NAME (Type): G.O. Himmelwright, M.D.
22e. ADDRESS: 133 Va. Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 21, 1972
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 26 1972
25b. REGISTRAR'S SIGNATURE: Sidney M. Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15025

15027

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	SEAN VERNON BENJAMIN MAYHEW	2a. DATE OF DEATH Month / Day / Year	10 / 21 / 72	2b. HOUR	1:25 P M	
3. SEX	male	4. RACE	white	5. DATE OF BIRTH	10-20-72	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS 24 / MIN. 15
7a. BIRTHPLACE (State or foreign country)	md.	7b. CITIZEN OF WHAT COUNTRY?	Allegany	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Allegany Cumberland, Md.
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	None	12b. KIND OF BUSINESS OR INDUSTRY	None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Parents-Maryland	13b. COUNTY	Parents-Allegany-Cumberland	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER	Parents-508 Decatur St.
14. FATHER'S NAME First / Middle / Last	Vernon B. MAYHEW	15. MOTHER'S MAIDEN NAME First / Middle / Last	MARETTA L. Emerick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	No	(If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	None	17. INFORMANT Address	Mr. Vernon Mayhew, Cumberland, Md. Father

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	7769 Brain damage	21 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Anoxia	21 hrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Tension pneumothorax - Reduced	1 hr.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Aspiration of meconium

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—		

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Oct 21, 19 72, to _____, 19____, that (I) ~~(we)~~ last saw the deceased alive on Oct 21 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	R. A. Reiter M.D.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED	Oct. 21, 1972
22d. PHYSICIAN'S NAME (Type)	Dr. R. A. Reiter, M. D.					22e. ADDRESS	909 Frederick St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Oct. 23, 1972	Sunset Memorial Park	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS	James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE	OCT 26 1972	25b. REGISTRAR'S SIGNATURE Sidney M. Norton

DHMH-16 1/71 30M
(VR A15 (4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15026

15028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: ROBERT	Middle: MILNOR	Last: MC KENZIE, SR.	2a. DATE OF DEATH Month: 10	Day: 23	Year: 72	2b. HOUR: 4:45A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: April 9, 1900	6. AGE (In years last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Regrig. Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Fibres Celanese				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cresaptown,	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: Brant Rd.			
14. FATHER'S NAME First: Milnor	Middle: J.	Last: McKenzie	15. MOTHER'S MAIDEN NAME First: Frances	Middle: --	Last: Maloney		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Sylvia A. McKenzie	Address: Cresaptown, Md. Rt. # 6 Box 394C			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart failure. — 492X

DUE TO, OR AS A CONSEQUENCE OF (b): Obstructive lung disease.

DUE TO, OR AS A CONSEQUENCE OF (c): Pulmonary Emphysema.

Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion deoth occurred on the dote and haur and from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: Clarence A. Vincent M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 10/23/72
22d. PHYSICIAN'S NAME (Type): C. VINCENT, M.D.		22e. ADDRESS: 924 SETON DRIVE, CUMBERLAND, MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/25/72	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park,	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: George GEORGE FUNERAL HOME,	ADDRESS: 202 GREENE STREET, CUMBERLAND, MD. 21502	25a. REC'D BY REGISTRAR DATE: OCT 27 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

15027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item#5,Film G453 10/25/72 kam

15029

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ALBERTA	S.	MILLER	OCT. 2, 1972	NOON PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	OCT. 14, 1887 (1884)	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	WIDOWED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg MARYLAND	HOSPITAL DOA FROSTBURG COMM.	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES X NO	148 BOWERY STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		STEVENSON	SARAH	ELLA	WINTERS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT
NO	N.A.	NONE	MR. EDGAR MILLER, 146 BOWERY ST., FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (a)	Chronic myocarditis	—
DUE TO, OR AS A CONSEQUENCE OF (b)	Hyper Tension C-V disease	—
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	—

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Senility

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO X	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 5-10, 1960, to 10-2, 1972, that (I) (~~we~~) last saw the deceased alive on 9-29 1972, and that in (my) (~~our~~) opinian death accurred an the date and hour and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H. C. Diehl M.D.		X			10-4-72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
H. C. DIEHL, M.D.	39 W. MAIN STREET, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/5/72	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24. NAME AND TITLE OF FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Marilou M. Sowers MARILOU M. SOWERS, FUNERAL HOME	HAFER-SOWERS-FROSTBURG 60 W. MAIN	OCT 16 1972	Lindsay M. Norton

VR A (5-71) 45M - 1/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1502S

15031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	HARRY	MINNICKS	Oct. 17, 72	12:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	Aug. 11, 1916	56 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U. S. A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	Sacred Heart Hosp.	Equipm't Opr. (Streets)	City of Cumberland.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES ☒ NO ☐	840 Greene St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	E.	Minnicks	Adeline	--	Lowery

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes.	W. W. # 2	220-10-7485	Mrs. Betty L. Minnicks	840 Greene St. Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial failure, acute	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple myocardial infarctions	Recent-1965
DUE TO, OR AS A CONSEQUENCE OF (c)	Multiple Coronary occlusion	Recent-1965

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerotic Heart Disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from July 71, to Oct 17, 72, that (I) (we) last saw the deceased alive on 10/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
S. G. Weisman	M.D.				10/19/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
S. G. WEISMAN, M.D.	59 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/20/72	Sunset Memorial Park,	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George GEORGE FUNERAL HOME, 202 GREENE ST, CUMB., MD.	OCT 24 1972	Sidney H. Norton

DHMH - 16 3/72 25M
(VR A15 (4))

15025

GEORGE HARRY HUMPHRIES

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15029

15032

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (See Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Margaret	Middle: L.	Last: Morgan	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 10 Day: 17 Year: 19 72	2b. HOUR 210 P M			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3-6-1884	6. AGE (In years last birthday) 88 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month: 10 Day: 17 Year: 19 72	2d. HOUR 11 P M		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Flintstone	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Flintstone Md.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Farm				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Flintstone	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER			
14. FATHER'S NAME First: Edward	Middle	Last: Lewis	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Thomas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Mrs. Mary Robinette	ADDRESS: Flintstone Md.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]	
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED: 10/17/72

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-20-72	23c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park	23d. LOCATION (City or Town) (County) (State): Frostburg Alleg. Md.	
24. FUNERAL DIRECTOR: Hafer-Sowers Funeral Home	ADDRESS: Marlow M. Sowers 60 W. Main St Frostburg Md.	25a. REC'D BY REGISTRAR DATE: OCT 24 1972	25b. REGISTRAR'S SIGNATURE: Sidney [illegible]	

DHMH-17 1/71 10M
(VR A15ME (5))

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15030

15033

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BABY	BOY	MORRIS	10	25	1972	2:40PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	Oct. 25, 1972				2	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	None	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Parents Md.	Parents-Alleg.	Cumberland		Parents-16 Virginia Ave.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Francis Morris	Shirley Lewis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	None	Mr. Francis Morris, Cumberland, Md. Father

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

7769

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) NON-VIABLE LUNGS

DUE TO, OR AS A CONSEQUENCE OF

(c) Premature Delivery at 22wks Gestation

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, natity medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/25, 19 72, to 10/25, 19 72, that (I) (we) last saw the deceased alive on 10/25 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert J. Dawson MD		☒	☐	☐	Oct. 26, 1972

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Robert J. Dawson, M.D.	500 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 26, 1972	St. Joseph Cemetery	Midland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 30 1972	Lindsay H. Norton

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15031

15034

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	Anna	Florence	Morrissey

2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Oct. Day 7, Year 1972 — 2b. HOUR 5:30 PM

2c. DATE PRONOUNCED DEAD Month Oct. Day 7, Year 1972 — 2d. HOUR 5:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	White	Apr. 13, 1902	70 YRS.		

7a. BIRTHPLACE (State or foreign country) Penna. — 7b. CITIZEN OF WHAT COUNTRY? U. S. A. — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. COUNTY OF DEATH Allegany Md.

10. CITY OR TOWN OF DEATH Cumberland, — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) V. O. A. Memorial Hosp. — 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife — 12b. KIND OF BUSINESS OR INDUSTRY Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland — 13b. COUNTY Allegany — 13c. CITY OR TOWN Cumberland — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER 135 N. Mechanic St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	--	Garlick	Alice	--	O'Neal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, — (If yes give war or dates of service) — 16b. SOCIAL SECURITY NO. None — 17. INFORMANT Mr. John N. Morrissey, Jr. ADDRESS 547 Patterson Ave Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED Oct. 7, 1972

ADDRESS(Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/10/72	S. S. Peter & Paul	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumb.Md.	OCT 13 1972	Sidney N. Norton

DHMH-17 1/71 10M
(VR A15ME 5)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15032 — 15035

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 25m-1/70

1. DECEASED-NAME (Type or print)	First: MARY	Middle: J.	Last: MURRAY	2a. DATE OF DEATH Month: OCTOBER Day: 28, Year: 1972	2b. HOUR: M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: MARCH 18, 1885	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): OHIO	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): FBG COMMUNITY HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CAFATERIA WORKER	12b. KIND OF BUSINESS OR INDUSTRY: STATE COLLEGE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 30 BEALL STREET		
14. FATHER'S NAME First: DAVID	Middle	Last: MURRAY	15. MOTHER'S MAIDEN NAME First: CATHERINE	Middle	Last: LAVIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-44-9515T	17. INFORMANT: MISS NOREEN MURRAY,	Address: 84 BROADWAY, FROSTBURG, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Ascending Colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

1530

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ACVD

19a. DATE OF OPERATION: ✓	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: ✓	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month ✓ Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ✓

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓	21f. LOCATION Street or R.F.D. No. ✓	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from AUGUST 19 70, to 28 OCT., 19 72, that (I) (we) last saw the deceased alive on 28 OCTOBER 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin M. Rothstein DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: 10/30/72	
22d. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN, M.D.	22e. ADDRESS: 48 BROADWAY, FROSTBURG, MD. 21532				

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10-31-1972	23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAELS CEMETERY	23d. LOCATION (City or Town) (County) (State): FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: JOSEPH R. DURST SR.,	ADDRESS: FROSTBURG, MD. 21532	25a. REG'D BY REGISTRAR DATE: NOV 3 1972	25b. REGISTRAR'S SIGNATURE: Dorothy Horton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15033

15036

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: PHOEBE	Middle:	Last: NEWLON	2a. DATE OF DEATH Month: 10 Day: 06 Year: 72		2b. HOUR: 2:10PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Sept. 24, 1881	6. AGE (In years last birthday): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): H.W.	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Luke	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 307 Pratt		
14. FATHER'S NAME First: John	Middle: T	Last: Zais	15. MOTHER'S MAIDEN NAME First: Phoebe	Middle:	Last: Wolford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Floyd Newlon	Address: Luke, Md.			

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 4379	Cerebrovascular Accident	1h
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Coronary artery disease Urinary Infection

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-8-72	
22d. PHYSICIAN'S NAME (Type) FOR: EARL W. CAMPBELL, M.D.	22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/9/72	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d. LOCATION (City or Town) (County) (State): Westernport, Allegany-Md.	
24. FUNERAL DIRECTOR: BOAL'S FUNERAL HOME, WESTERNPORT, MD.	ADDRESS: 111 CHURCH STREET	25a. RECD BY REGISTRAR DATE: OCT 13 1972	25b. REGISTRAR'S SIGNATURE: Lindsay H. Norton	

E. J. Boal

DHMH - 163/72 25M
(VR A15 (4))

15033

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form #MA Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

15034

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15037

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Charles	William	Nickel

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month Oct. Day 29 Year 1972 — 2b. HOUR 12 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN
Male	White	Oct.3,1899	73 YRS.				

2c. DATE PRONOUNCED DEAD Month Oct. Day 29 Year 1972 — 2d. HOUR 12 M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Retired Salesman	Dairy

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	41 New Hampshire Ave.

14. FATHER'S NAME First Middle Lost	15. MOTHER'S MAIDEN NAME First Middle Lost
John G. Nickel	Laura Stevens

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		Mrs. Mildred Nickel, Cumberland, Md. Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	**--**
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate couse (a). stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** thot I took chorge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my opinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr.Benedict Skitarelic, M. C.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED Oct. 29,1972

Cumberland,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov.1,1972	Sunset Memorial Park	Cumberland,Allegany,Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	NOV 6 1972	Sidney M. Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15035 — 15038

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/72 25M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: C.	Last: OFTEN	2a. DATE OF DEATH Month: 10	Day: 26	Year: 72	2b. HOUR: 3:00A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: June 22, 1896	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Electrician	12b. KIND OF BUSINESS OR INDUSTRY: Textile				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rt.5-Winchester Road			
14. FATHER'S NAME First / Middle / Lost: Patrick Often		15. MOTHER'S MAIDEN NAME First / Middle / Last: Anna Kritzburg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: Mrs. Goldie Often, Winchester Road-Wife				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Intra- Cerbral Haemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b): Cerebral Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

4319

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Prostatic Hypertrophy.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (aur) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clarence J. Vincent M.D.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): DR. C. VINCENT		22e. ADDRESS: SETON DRIVE, CUMB. MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 28, 1972	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR ADDRESS: SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB.		25a. REC'D BY REGISTRAR DATE: OCT 30 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

15035

JOHN C. OFTEN 10 26 72 2:00P

SACRED HEART HOSPITAL

DR. C. VINCENT SETON DRIVE, CUMB. MD. 21502

SCARPELLI FUNERAL HOME, 109 VA. AVE., CUMB.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15036 — 15039

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1. DECEASED-NAME (Type or print)	First: Sarah	Middle:	Last: Parry	2a. DATE OF DEATH (Month, Day, Year) @ 10:05 A.M.	October 20, 1972	2b. HOUR: A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3/10/1880	6. AGE (In years last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): England	7b. CITIZEN OF WHAT COUNTRY?: U.S. of America	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany County Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Midlothian	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER		
14. FATHER'S NAME First: Mark	Middle:	Last: Carpenter	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle:	Last: Jones	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 213-09-6444 D	17. INFORMANT: P.O.Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial failure sec to
DUE TO, OR AS A CONSEQUENCE OF
(b): Arteriosclerotic Heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) — (b) yrs — (c) yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify thot (I) (this hospitol) ottended the deceased from Feb. 4, 1972, to Oct. 20, 1972, that (I) (we) lost saw the deceased olive on Oct. 19, 1972, and thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE: George M Simons M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): George M. Simons, M. D. — 22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-23-1972	23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State): Frostburg, Allegany, Md.	
24. FUNERAL DIRECTOR: Joseph R. Durst Sr.	ADDRESS: Frostburg, Md. 21532	25a. REC'D BY REGISTRAR DATE: OCT 26 1972	25b. REGISTRAR'S SIGNATURE: Sidney M Norton	

4 1

FOR STATE HEALTH DEPT.

15037

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15040

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office (Forensic Pathology) with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First / Middle / Last: Frank A. Poorbaugh					2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 10-12-72 19	2b. HOUR: 7:30 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-18-31	6. AGE (In years last birthday): 40 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month October Day 12, Year 1972 19	2d. HOUR: 7:30 PM
7a. BIRTHPLACE (State or foreign country): Penna	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penna	13b. COUNTY: ~~Somerset~~ Bedford	13c. CITY OR TOWN: Fairhope	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R# 1			
14. FATHER'S NAME First / Middle / Last: Franklin Andrew Poorbaugh		15. MOTHER'S MAIDEN NAME First / Middle / Last: Florence Irene Clites Poorbaugh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 199-30-4630	17. INFORMANT ADDRESS: Mrs. Mary Clauson Poorbaugh, Fairhope RD#1 Pa.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Crushed Face	Minutes
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Explosion of Truck Tire	"
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 7 10-12-72	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Tire blew up, force striking in face.
21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Farm	21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Rt. #1, Fairhope, Somerset, Penna.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: October 12, 1972
ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: October 15, 1972	23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State): Berlin RD#1 Somerset Pa.	
24. FUNERAL DIRECTOR ADDRESS: ZIEGLER FUNERAL HOME, HYNDMAN, PENNSYLVANIA		25a. REC'D BY REGISTRAR DATE: OCT 18 1972	25b. REGISTRAR'S SIGNATURE: Nancy H. Norton	

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15038 — 15041

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ERNEST	Middle:	Last: POSSELT	2a. DATE OF DEATH Month Day Year: OCTOBER 27, 1972	2b. HOUR: 11:30 P M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: AUGUST 17, 1897	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): AUSTRIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): AWNING AND UPHOLSTER	12b. KIND OF BUSINESS OR INDUSTRY: BUSINESS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 1311 FREDERICK STREET		
14. FATHER'S NAME First: HERMAN	Middle:	Last: POSSELT	15. MOTHER'S MAIDEN NAME First: ANNA	Middle:	Last: UNKNOWN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-32-3336	17. INFORMANT: JOHANNA POSSELT	Address: 1311 FREDERICK ST. CUMBERLAND			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive heart failure	1 day
DUE TO, OR AS A CONSEQUENCE OF (b)	myocardial disease	2 years
DUE TO, OR AS A CONSEQUENCE OF (c)	coronary disease	2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from 10-14, 1972, to 10-27, 1972, that (I) (we) last saw the deceased alive on 10-27 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: L Brings MD	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10-28-72	
22d. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.	22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: OCTOBER 30 72	23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL HOME, CUMBERLAND, MD.	ADDRESS: 40 DECATUR ST.	25a. REC'D BY REGISTRAR DATE: NOV 1 1972	25b. REGISTRAR'S SIGNATURE: Sidney Horton	

DHMH - 163/7225M
(VR A15 (4))

15039

ERNEST MOSSELY OCTOBER 27, 1972 11:30

1

15039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15042

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: HENRY	Middle: A.	Last: POWELL	2a. DATE OF DEATH Month: 10 Day: 8 Year: 72	2b. HOUR: 5:40PM		
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: 3-27-1895	6. AGE (In years last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): W.Va	7b. CITIZEN OF WHAT COUNTRY?: usa	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY: retired				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Romney	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Washington, St			
14. FATHER'S NAME First: Albert	Middle: P.	Last: Powell	15. MOTHER'S MAIDEN NAME First: Virginia	Middle: B.	Last: Cummins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 232-09-0521	17. INFORMANT: Ida Powell	Address: Romney, W.Va				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Cerebrovascular insuff

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4379

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: a few minutes / hours / many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/2/72, 19 to 10/8, 19 72, that (I) (we) last saw the deceased alive on 10/7, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. Powell MD	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10-10-72	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-10-72	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer	23d. LOCATION (City or Town) (County) (State): Romney Hamp. W.Va	
24. FUNERAL DIRECTOR: Larry Powell	ADDRESS: Romney, W.Va	25a. REC'D BY REGISTRAR DATE: OCT 17 1972	25b. REGISTRAR'S SIGNATURE: Audrey H Norton	

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15040

15043

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First: Charles	Middle: V.	Last: Ralston	2a. DATE KNOWN OF ESTIMATED DEATH: Month Oct. Day XX 9-2-72 Year 19			2b. HOUR 6a M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Nov. 30, 1895	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month October 2, Day Year 19 72	2d. HOUR 2 p M
7a. BIRTHPLACE (State or foreign country): W. Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 414 N. Mechanic St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Salesman	12b. KIND OF BUSINESS OR INDUSTRY: Household				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 414 N. Mechanic St.			
14. FATHER'S NAME First: Charles	Middle: E.	Last: Ralston	15. MOTHER'S MAIDEN NAME First: Ida	Middle: B.	Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): Navy	16b. SOCIAL SECURITY NO.: 219-03-9719	17. INFORMANT: Adrian Ralston, Cumberland, Md.	ADDRESS: Nephew			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Myocardial hypertrophy; Chronic Pericarditis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: OCTOBER 2, 1972

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 5, 1972	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 11 1972	25b. REGISTRAR'S SIGNATURE: Sidney L. Norton	

DHMH-171-1171 10M
(VR A 15ME (5))

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15041 — 15044

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Charles	Middle: E.	Last: Rockwell	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: Oct. 12 1972	2b. HOUR: 7P M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Feb. 25, 1900	6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Oct. Day 12 Year 1972	2d. HOUR: 7P M
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.U.A. Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY: Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 13 B Jane Frazier Village	
14. FATHER'S NAME First / Middle / Last: Edward Rockwell		15. MOTHER'S MAIDEN NAME First / Middle / Last: Emma K. Brubaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Daughter	ADDRESS: Mrs. Kathleen Hockaday, Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Sclerosis — ------
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED: Oct. 12, 1972

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 15, 1972	23c. NAME OF CEMETERY OR CREMATORY: Abe Cemetery	23d. LOCATION (City or Town) (County) (State): Wiley Ford, W. Va.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 17 1972	25b. REGISTRAR'S SIGNATURE: Sidney L. Norton	

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15042 — 15045

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M
(VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month / Day / Year
Harry	E	Schaidt	October 13 72

2b. HOUR: 7:55 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	2-11-13	59 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Cumberland, Md.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Lions Manor Nursing Home	Steel Worker	Cutter

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	111 E. Mary St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Peter		Schaidt	Nellie		See

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	War II	214-05-9064	Lions Manor N.H. Office, Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cardiac failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Cachexia - malnutrition — few months

DUE TO, OR AS A CONSEQUENCE OF

(c) Bronchogenic carcinoma with metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1579

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner)	UNDERLYING CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from Sept 13, 1972, to Oct 13, 1972, that (I) (we) last saw the deceased alive on Oct 12 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John A Topper	MD	[ ]	[X]	[ ]	10-14-72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A Topper MD	Hyndman Pa

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 16, 1972	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 19 1972	

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15043

15046

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Lost	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month	Doy	Yeor	2b. HOUR
JOSEPH	F.	SCOTT	OCT.	31,	1972	5:00 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month / Doy / Yeor	2d. HOUR
MALE	WHITE	AUG. 2, 1910	62 YRS.			OCT. 31, 1972	5:00 PM
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH			
MARYLAND	U.S.A.		ALLEGANY Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
FROSTBURG	FROSTBURG COMM. HOSP. DOA	LABORER	CELANESE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER		
MARYLAND	ALLEGANY	FROSTBURG	YES [X] NO [ ]	123 S. WATER STREET		
14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost	
JAMES	H.	SCOTT	BARBARA		FATKIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
NO	N.A.	214-07-5354	MRS. JOSEPH F. SCOTT, 123 S. WATER,	FROSTBURG, MD.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	-----
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 10/30/72

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	11/3/72	VALE SUMMIT CEMETERY	VALE SUMMIT ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS: HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG,

25a. REC'D BY REGISTRAR DATE NOV 8 1972

25b. REGISTRAR'S SIGNATURE Evelyn Norton

DHMH-17 (VR A15ME (5))

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part 1 on line 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15044

15047

1. DECEASED-NAME (Type or Print) First: Walter	Middle: Henry	Lost: Shroyer	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Doy Yeor: Oct. 2, 1972	2b. HOUR: 6:57 PM		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 5-1-91	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Doy Yeor 19: October 2, 1972	2d. HOUR: 6:57 PM
7a. BIRTHPLACE (State or foreign country): Penna	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Sacred Heart Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penna	13b. COUNTY: Bedford	13c. CITY OR TOWN: Hyndman	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Rt. #1			
14. FATHER'S NAME First: Nathaniel	Middle	Lost: Shroyer	15. MOTHER'S MAIDEN NAME First: Ellen	Middle	Lost: Shaffer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-07-6731	17. INFORMANT ADDRESS: Sacred Heart Hospital-Cumberland, Maryland					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒☒ and in my apinian death resulted from: Natural causes ☒☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒☒

22b. DATE SIGNED: OCTOBER 2, 1972

ADDRESS(Street, city, town or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct.5,1972	23c. NAME OF CEMETERY OR CREMATORY: Comps Cemetery	23d. LOCATION (City or Town) (County) (State): Hyndman, Rd#1, Somerset Co., Pa.	
24. FUNERAL DIRECTOR: ZIEGLER FUNERAL HOME,	ADDRESS: HYNDMAN, PENNSYLVANIA 15545	25a. REC'D BY REGISTRAR DATE: OCT 6 1972	25b. REGISTRAR'S SIGNATURE: Sidney M Norton	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15045 — 15048

1. DECEASED-NAME (Type or print): First JOHN; Middle EDWARD; Last SMITH
2a. DATE OF DEATH: Month OCTOBER; Day 26; Year 1972
2b. HOUR: 10:29 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 3/24/1889
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): W.Va
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired C & P R.R
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Allegany
13c. CITY OR TOWN: Lonaconing
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 2 Douglas Avenue
14. FATHER'S NAME: First Joseph; Middle; Last Smith
15. MOTHER'S MAIDEN NAME: First Agnes; Middle; Last Dayton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jeanette Neat "Daughter" Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO, OR AS A CONSEQUENCE OF
(b): myocardial disease — 2 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c): Coronary thrombosis — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from 10-24, 19 72, to 10-26, 19 72, that (I) (we) last saw the deceased alive on 10-26 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. Brings MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-26-72
22d. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.
22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/29/72
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park
23d. LOCATION (City or Town) (County) (State): Frostburg A. Md
24. FUNERAL DIRECTOR (Name and ADDRESS): EICHHORN FUNERAL HOME, 8 E. MAIN STREET, LONACONING, MD. 21539
25a. REC'D BY REGISTRAR DATE: OCT 30 1972
25b. REGISTRAR'S SIGNATURE: Sidney [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene priar to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH - 163/72 25M
(VR A15 (4))

15043

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15046 — 15049

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARGARET	Middle: LEE HAZEL	Last: SNIDER	2a. DATE OF DEATH: Month 10 Day 05 Year 72	2b. HOUR: M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Sept. 9, 1900	6. AGE (In years last birthday): 72 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): W.Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Ridgeley	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Route 1	
14. FATHER'S NAME First / Middle / Last: Evan Hiett		15. MOTHER'S MAIDEN NAME First / Middle / Last: Annie Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mr. Nealon Snider	Address: Ridgeley, W.Va.	Husband	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	2 Days
DUE TO, OR AS A CONSEQUENCE OF (b)	Atrial fibrillation	2 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Artery Disease	unk

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus - Hysterectomy Edema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** that (I) (this hospitol) ottended the deceosed from 10/4, 19 22, to 10/5, 19 22, that (I) (we) lost saw the deceased alive an ____, 19 ____, and thot in (my) (our) opinion death occurred on the date and haur and from the causes stated abave. (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: J.A. Pagan	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10/5/72		
22d. PHYSICIAN'S NAME (Type): J.A. PAGAN, M.D.	22e. ADDRESS: 1068 NATIONAL HWY., LA VALE, MD. 21502			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 8, 1972	23c. NAME OF CEMETERY OR CREMATORY: Augusta Cemetery	23d. LOCATION (City or Town) (County) (State): Augusta, W.Va.	
24. FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME	ADDRESS: 108 VIRGINIA AVE., CUMBERLAND, MD. 21502	25a. REC'D BY REGISTRAR DATE: OCT 17 1972	25b. REGISTRAR'S SIGNATURE: Audrey H. Norton	

DHMH - 163/72 25A (VR A15 (4))

1

FOR STATE HEALTH DEPT.

15047

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15050

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: Carrie	Middle: Mae	Lost: Snyder	2a. DATE KNOWN [X] OF DEATH ESTIMATED [ ]: Month 10- Doy 2- Year 1972	2b. HOUR 6:40p M		
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Jan. 8, 1889	6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.	2c. DATE PRONOUNCED DEAD Month October Doy 2, Year 1972	2d. HOUR 6:40p M	
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Wiley Ford	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Route 1		
14. FATHER'S NAME First: William Middle: Gibson Lost:	15. MOTHER'S MAIDEN NAME First: Rebecca Middle: Grant Lost:					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 233-7409697	17. INFORMANT: Mrs. Camilla Dressman	ADDRESS: LaVale, Md.	Daughter		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	"
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: OCTOBER 2, 1972

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 5, 1972	23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 11 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

DHMH-17 1/73 10M (VR AISME 5)

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15048 — 15051

1. DECEASED-NAME (Type or Print): First: Irvin; Middle: ; Last: Steinmetz

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month Doy Year: 10-7-72 19 7: 25a M

2b. HOUR

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Feb. 10, 1890

6. AGE (In years last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

2c. DATE PRONOUNCED DEAD: Month OCTOBER Day 7 Year 19 7: 25a M

2d. HOUR

7a. BIRTHPLACE (State or foreign country): N. J.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Cumberland

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Trackman

12b. KIND OF BUSINESS OR INDUSTRY: Railroad

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Cumberland

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER: 934 Maryland Ave.

14. FATHER'S NAME: First Oscar; Middle ; Last Steinmetz

15. MOTHER'S MAIDEN NAME: First Sarah; Middle ; Last Koegel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.:

17. INFORMANT ADDRESS: Mrs. Mary E. Steinmetz, Cumberland Md. Wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): SHOCK — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: HOURS

4412

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): RUPTURED ABDOMINAL ANEURYSM — "

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)

21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: OCTOBER 7, 1972

ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Oct. 9, 1972

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d. LOCATION (City or Town) (County) (Stote): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: James F. Scarpelli

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: OCT 17 1972

25b. REGISTRAR'S SIGNATURE: Sidney H. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Cms. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 FOM
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15049 — 15052

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 163/7225M (VR A15 (4))

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
HELEN	LEONA	STEWART	10 19 72

2b. HOUR: M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	April 17, 1913	59 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
W. Va.	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	SACRED HEART HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
W. Va.	Mineral			Rt 2 Keyser

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ray W.		Maine	Flora		Biser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	213 24 6018	John W. Stewart	Hanover, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CVA	5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	MI	3 days
DUE TO, OR AS A CONSEQUENCE OF (c)	Congestive Heart Failure Arterio Sclerosis	3 days 30 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospitol) attended the deceased from Sept 14, 1972 to Oct 19, 1972 that (I) (we) last saw the deceased alive on Oct 19 1972 and that in (my) (our) opinian death occurred an the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Barbara Schindler M.D.	M.D.				10/24/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. B. SCHINDLER, M.D.	43 GREENE ST, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	22 Oct 72	Rest Lawn Mem.	LaVale Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROTRUCK FUNERAL HOME Allen M. Rotruck	KEYSER, W. VA.	OCT 26 1972	Sidney M. Norton

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15050 — 15053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print): First RUSSELL; Middle E.; Last STEWART
2a. DATE OF DEATH: Month 10; Day 13; Year 72
2b. HOUR: 7:15 AM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: May 5, 1903
6. AGE (In years last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): W, Va.
7b. CITIZEN OF WHAT COUNTRY?: U. S.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Koppers Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W, Va.
13b. COUNTY: Hampshire
13c. CITY OR TOWN: Green Spring
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Rural
14. FATHER'S NAME: First George; Middle R.; Last Stewart
15. MOTHER'S MAIDEN NAME: First Fannie; Middle; Last Stewart
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 236-03-5637
17. INFORMANT: Address: Beulah M. Stewart, Green Spring, W, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 13 days
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic CVD — 5
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medicol examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State
Cumberland Md Alleg

22a. I certify that (I) (this haspitol) attended the deceased from 10/12/72, 19____, to 10/13/72, 19____, that (I) (we) last saw the deceased alive on 10/12/72, 19____, and that in (my) (our) opinion death occurred on the date and haur and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. J. Williams MD
DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10/14/72
22d. PHYSICIAN'S NAME (Type): R. J. Williams
22e. ADDRESS: 122 S. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/16/72
23c. NAME OF CEMETERY OR CREMATORY: Forest Glen Cemetery
23d. LOCATION (City or Town) (County) (State): Green Spring Hampshire W, Va.

24. FUNERAL DIRECTOR: ADDRESS: Keith S. Shaffer, Romney, W, Va.
25a. REC'D BY REGISTRAR DATE: OCT 20 1972
25b. REGISTRAR'S SIGNATURE: Lindsay Norton

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15051 — 15054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25m-1/70

1. DECEASED-NAME (Type or print): First: Ralph; Middle: ; Last: Tagliaferre
2a. DATE OF DEATH: Month: October; Day: 29; Year: 1972
2b. HOUR: 2:00 A.M. A.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 9/16/1890
6. AGE (In years last birthday): 82 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Naples, Italy
7b. CITIZEN OF WHAT COUNTRY?: U.S. of America
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegany County Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired: B. & O. R.R. carman
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 701 Bedford Street
14. FATHER'S NAME: First: Joseph; Middle: ; Last: Tagliaferre
15. MOTHER'S MAIDEN NAME: First: Antonette; Middle: ; Last: Pennica
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 214-07-0167A
17. INFORMANT: P.O.Box 599, Cumberland, Md. 21502 (Address): Allegany County Infirmary records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident
4369
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c): Parkinson's Disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7/15, 1971, to 10/29, 1972 that (I) (we) last saw the deceased alive on 10/28 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Geo. M. Simons M.D. DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. DATE SIGNED: 10/29/72
22d. PHYSICIAN'S NAME (Type): George M. Simons, M. D.
22e. ADDRESS: Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/1/72
23c. NAME OF CEMETERY OR CREMATORY: RoseHill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. ADDRESS: Cumberland, Md 21502
25a. REC'D BY REGISTRAR DATE: NOV 6 1972
25b. REGISTRAR'S SIGNATURE: Sidney S. Horton

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15052 — 15055

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in steps 18, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Doy Year	2b. HOUR
JAMES	CHARLES	TICHY	10-24-72 19	9:30a M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.	2c. DATE PRONOUNCED DEAD Month Doy Year	2d. HOUR
MALE	WHITE	19 FEB. 1895	77 YRS.	October 24, 1972 19	10:00a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH	
MARYLAND	U, S. A.		ALLEGANY	Md.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
R#2 Flintstone	Rt.#2 Flintstone	RETIRED LABORER	Maint.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Penna	Bedford	Flintstone	YES ☐ NO ☒	Route # " 2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last			
WEUCESLAUS		TICHY	MARIE	NEE	LEVY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				
NO		214-07-3327	MARGARET TICHY	RFD# 2 FLINTSTONE, MD. BOX 204				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒	
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Year HOUR A.M. P.M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that I took charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED October 24, 1972

ADDRESS(Street, city, town, or county) Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)	
BURIAL	27 OCT. 1972	SUNSET MEMORIAL PARK	CUMBERLAND ALLEGANY MARYLAND	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
SILCOX-MERRITT FUNERAL SERVICE-CUMBERLAND, MD.		OCT 26 1972	Sidney H. Norton	

DHMH-17 1/71 10M
(VR A15ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15053 — 15056

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year / 2b. HOUR
MARGARET		TRANUM	OCTOBER	14,	1972 / 2:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	OCTOBER 9, 1889	83 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	D.U.A. FBG COMMUNITY HOSP.	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES ☒ NO ☐	33 WASHINGTON STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DAVID		NEILSON	MARGARET		SHAW

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	213-44-1762	EIMER J. TRANUM,	33 WASHINGTON ST. FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 4109 Coronary Occlusion

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Advanced A.V.D

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 or 3 minutes / years / 20 yrs +

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
✓	✓	YES ☐ NO ☒	✓

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	✓	✓

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	✓	✓			

22a. I certify that (I) (this hospital) attended the deceased from JUNE, 1970, to 10-14, 1972, that (I) (we) last saw the deceased alive on 10-12 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Martin M Rothstein	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	10/15/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN, M.D.	48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10-16-1972	FROSTBURG MEMORIAL PARK	FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST SR., FROSTBURG, MD. 21532	OCT 18 1972	[illegible]

DHMH-16 1/71 30M (VR A15-74)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15054 — 15057

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ANNABELLE	Middle:	Last: TRULY	2a. DATE OF DEATH: Month 10 Day 05 Year 72	2b. HOUR: M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: FEBRUARY 20, 1886	6. AGE (In years last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 207 ALBERT AVENUE		
14. FATHER'S NAME First: HENRY	Middle:	Last: STEVENS	15. MOTHER'S MAIDEN NAME First: SARAH	Middle:	Last: DAVIS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-16-2032D	17. INFORMANT: GRAHAM TRULY, FROSTBURG, MD.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC AND CORONARY HEART DISEASE — 5 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CVA 1972

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 1 - 3, 1970, to 10 - 5, 1972, that (I) (we) last saw the deceased alive on 10 - 5 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. Ballin M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-5-72	
22d. PHYSICIAN'S NAME (Type): R. BALLIN, M.D.	22e. ADDRESS: 51 GREENE ST., CUMBERLAND, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: OCT. 8 '72	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24. FUNERAL DIRECTOR: DURST FUNERAL HOME	ADDRESS: 57 FROST AVE., FROSTBURG, MD	25a. REC'D BY REGISTRAR DATE: OCT 11 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

DHMH - 163/72 25M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15055 — 15058

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print)	First: ELSIE	Middle: P.	Last: WAGONER	
2a. DATE OF DEATH	10- Month 30 Day 72 Year	2b. HOUR	M	
3. SEX	Female			
4. RACE	White			
5. DATE OF BIRTH	Sept. 3, 1896			
6. AGE (In years last birthday)	76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	W. Va.			
7b. CITIZEN OF WHAT COUNTRY?	USA			
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐				
9. COUNTY OF DEATH	Allegany Md.			
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSP.			
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife			
12b. KIND OF BUSINESS OR INDUSTRY	Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	W.Va.	13b. COUNTY: Hampshire	13c. CITY OR TOWN: Springfield	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER	Route 1			
14. FATHER'S NAME	First: James	Middle: W.	Last: Ward	
15. MOTHER'S MAIDEN NAME	First: Mary	Middle: E.	Last: Derr	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No			
16b. SOCIAL SECURITY NO.				
17. INFORMANT	Address: Daughter Mrs. Edna Milleson, Springfield, W.Va.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Retaining Head Fall — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO, OR AS A CONSEQUENCE OF (b) OSTEO — yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING ☐	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 10 15 19 72 to 10 30 19 72 that (I) (we) last saw the deceased alive on 10 30 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. Guy Fiscus M.D. — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: Oct.31,1972

22d. PHYSICIAN'S NAME (Type): Dr.W. Guy Fiscus, M. D. — 22e. ADDRESS: Memorial Hospital Bldg. Cumberland Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: Nov.2,1972	23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery	23d. LOCATION (City or Town) (County) (State): Fort Ashby, W.Va.	
24. FUNERAL DIRECTOR / ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: NOV 6 1972	25b. REGISTRAR'S SIGNATURE: Lindsay Norton		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15056 — 15059

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Martha	Middle: W.	Last: Walker	2a. DATE OF DEATH: Month 10 Day 5 Year 72	2b. HOUR: 4:05 AM PM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3-19-80	6. AGE (In years last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Cumberland, Md	7b. CITIZEN OF WHAT COUNTRY?: American	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland, Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Lions Manor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Sales Lady	12b. KIND OF BUSINESS OR INDUSTRY: Retail		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumb. Md.	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 216 Davidson St.	
14. FATHER'S NAME First: David	Middle	Last: Walker	15. MOTHER'S MAIDEN NAME First: Lucy	Middle	Last: Litzenberg
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-0236	17. INFORMANT: A Martha Lee Heron	Address: 630 Frederick St. Cumb. Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO, OR AS A CONSEQUENCE OF, (b): Malnutrition - Anemia — approx 1 year
DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma Left breast with Metastasis — approx 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Excision Carcinoma L. Breast

19a. DATE OF OPERATION: 9-1-72	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biopsy - Left Breast	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from Sept 19, 1972, to Oct 5, 1972, that (I) (we) last saw the deceased alive on Oct 5 1972, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A. Topper MD — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐	22c. DATE SIGNED: 10-5-72		
22d. PHYSICIAN'S NAME (Type): Dr. John A. Topper, M.D.	22e. ADDRESS: Hyndman, Pa.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/7/72	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md.	
24. FUNERAL DIRECTOR: Silcox-Merritt Fun. Ser.	ADDRESS: 404 Decatur St. Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: OCT 10 1972	25b. REGISTRAR'S SIGNATURE: Sidney H. Norton	

DHMH - 16 3/72 25M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15057

CERTIFICATE OF DEATH

15060

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WALLACE	NEAL	WESTFALL	OCT. 5, 1972	8:55 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	NOV. 23, 1910	61 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	FROSTBURG COMM. HOSP.	LABORER	GRAVEL CO.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	ECKHART	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CLARENCE	O.	WESTFALL	PHOEBE	T.	BROWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	Address
NO	N.A. 234-14-5521	Hilda Lewis	Eckhart, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Embolism	15 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Liver failure - (cirrhosis ascites)	3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE	✓	YES ☐ NO ☒	✓

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	✓	✓

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	✓		✓		

22a. **I certify** that (I) (this hospital) attended the deceased from 9-20, 19 72, to 10-5, 1972, that (I) (we) last saw the deceased alive on 10-5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Martin M. Rothstein MD		☒	☐	☐	10/7/72

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MARTIN M. ROTHSTEIN, M.D.	48 BROADWAY, FROSTBURG, MD. 21532

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/8/72	ECKHART CEMETERY	ECKHART ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harper-Sowers Funeral Home, Marlow M. Sowers	60 W. MAIN, FROSTBURG	OCT 16 1972	Sidney L. Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15058 — 15061

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M (VR A15 (4))

1. DECEASED-NAME (Type or print): First OSCAR; Middle D.; Last WILLISON SR.
2a. DATE OF DEATH: Month 10; Day 20; Year 72
2b. HOUR: 7:50A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Aug. 22, 1917
6. AGE (In years last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): W. Va.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Washington Suburban
12b. KIND OF BUSINESS OR INDUSTRY: Water Works
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Prince George
13c. CITY OR TOWN: Cheverly
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 6209 Landover Road
14. FATHER'S NAME First Middle Last: Harvey Willison
15. MOTHER'S MAIDEN NAME First Middle Last: Susan Pyles
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16b. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs. Nell Willison, Cheverly, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4109 Hib. Myocardial infarction. Shock.
DUE TO, OR AS A CONSEQUENCE OF
(b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10/14, 19 72, to 10/20, 19 72, that (I) (we) last saw the deceased alive on 10/20 19 72, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P.B. Halmos MD DEGREE — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 10/21/72
22d. PHYSICIAN'S NAME (Type): P.B. HALMOS
22e. ADDRESS: 502 Schley St. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Oct. 24, 1972
23c. NAME OF CEMETERY OR CREMATORY: Fort Ashby Cemetery
23d. LOCATION (City or Town) (County) (State): Fort Ashby, W.Va.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 26 1972
25b. REGISTRAR'S SIGNATURE: Lincoln Watson

4102

1

FOR STATE HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15059

15062

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF ESTIMATED Month Day Year	2b. HOUR
EMMA	R.	YOUNG	OCT. 3, 1972	6:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
FEMALE	WHITE	AUG. 22, 1901	71 YRS.					Oct. 4, 1972	7:00 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	WIDOWED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	335 FAYETTE STREET	TEACHER	SCHOOL

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	335 FAYETTE STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		RICHARDS	MAMIE		PEEBLES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N.A.	215-20-6031	MRS. MARGARET H. SOWERS	24 E. MAIN ST., BONACONING, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES / NO

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X Inquiry X and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED OCT. 4, 1972

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/8/72	CEM. ST. LUKE'S CHURCH	CUMBERLAND, ALLEGANY, MD.

24. FUNERAL DIRECTOR ADDRESS: HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG, MD.

Marilou M. Sowers

25a. REC'D BY REGISTRAR DATE OCT 16 1972

25b. REGISTRAR'S SIGNATURE Audrey H. Norton

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FHR. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

DHMH-17 1/71 10M
(VR A15ME (5))